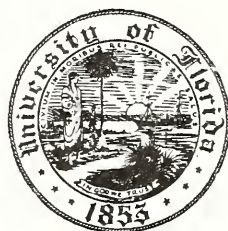





UNIVERSITY  
OF FLORIDA  
LIBRARIES







Digitized by the Internet Archive  
in 2010 with funding from  
Lyrasis Members and Sloan Foundation







---

## CHILD GUIDANCE PROCEDURES

---

## COLLABORATORS FROM THE STAFF

### INSTITUTE FOR JUVENILE RESEARCH

CORNELIA H. ALLEN, *Social Service*  
MARION O'BRIEN, *Social Service*  
ANDREW W. BROWN, *Psychology*  
TEMPLE BURLING, *Psychiatry*  
JOSEPHINE CLARK, *Social Service*  
MAXWELL GITELSON, *Psychiatry*  
MARY HARMS, *Social Service*  
AUGUSTA T. JAMESON, *Psychology*  
RICHARD L. JENKINS, *Pediatrics*  
IRENE JOSSELYN, *Psychiatry*  
MYRTLE MINK, *Social Service*  
J. P. MOLLOY, *Psychiatry*  
FRANCES C. PERCE, *Psychology*  
KATHARINE H. RANCK, *Social Service*  
MILDRED S. ROBINSON, *Recreation*  
CLIFFORD R. SHAW, *Sociology*  
MARGARET SVENDSEN, *Recreation*  
CLAUDIA WANNAMAKER, *Recreation*  
NELLIE WOODWARD, *Social Service*  
LILIAN DAVIS, *Editorial*

The Century Psychology Series  
Richard M. Elliott, Editor

---

# CHILD GUIDANCE PROCEDURES

Methods and Techniques Employed at  
the Institute for Juvenile Research

---

By  
THE STAFF OF THE INSTITUTE  
FOR JUVENILE RESEARCH

PAUL L. SCHROEDER, M.D., *Director*

INSTITUTE FOR JUVENILE RESEARCH  
CHICAGO, ILLINOIS



---

D. APPLETON-CENTURY COMPANY  
*Incorporated*  
NEW YORK LONDON

156.10  
I 290  
C. 2  
Copyright, 1937, by

D. Appleton-Century Company, Inc.

All rights reserved. This book, or parts thereof, must not be reproduced in any form without permission of the publishers.

3117

PRINTED IN THE UNITED STATES OF AMERICA

## PREFACE

For some years the staff of the Institute for Juvenile Research has recognized the need for a body of material which would aid students who come here for field training in psychiatry, social work, psychology, and sociology. They require orientation in child guidance practices, with special reference to the program of the Institute. With this purpose particularly in mind an attempt has been made in this book to summarize the thinking and procedures which have been found most fruitful at the Institute. In addition to helping students it is hoped that the book will prove useful to physicians, educators, social workers, court workers, and recreation leaders, who will probably find its chief value in the synopsis and orientation it may give them in professions other than their own. For example, the psychological material was not written for clinical psychologists, who may find it elementary, but to introduce those in allied fields to the viewpoint and methods of the psychologist in the child guidance clinic.

This volume was undertaken at the suggestion of one of the Institute psychiatrists, Dr. Temple Burling. A committee including representatives of each of the various departments was organized and met weekly under Dr. Burling's chairmanship. When he left the staff of the Institute Dr. R. L. Jenkins became chairman and assumed the major responsibility for the completion of this work. During the period of nearly three years in which the material has been assembled and reviewed, the personnel of the committee has changed to some extent, but at all times each of the departments of

the clinic has been represented, and the original conception of the book as a unified volume has been maintained. The book, from the inception of the idea, has been the joint product of the committee. Various chapters were drafted by different individuals, submitted to the committee, read and re-read, cut, grafted, or rewritten until a majority agreement was reached. Extreme views had to be compromised, and only that material was finally included upon which preponderant agreement could be reached and which was considered by a majority of the committee to be reasonably supported by experience. As a result of the scrutiny and stimulating criticism of the entire group, much of the material has been clarified beyond the initial thinking of the person making the contribution. Thus, the experience gained through this procedure of coöperative writing has been valued by the members of the committee.

The material presented in the section on therapy was gathered from cases seen at the Institute for Juvenile Research. The only changes that have been made are those essential for disguising confidential data. This has been done in such a way as not to affect the significant features of the situations that are described.



# CONTENTS

	PAGE
PART I. THE PROBLEM OF CHILD GUIDANCE	
I NATURE AND NEED OF CHILDHOOD	3
II EXISTENCE AND VARIETY OF PROBLEMS	10
III THE CHILD GUIDANCE APPROACH	20
PART II. THE DIAGNOSTIC STUDY	
IV ORGANIZATION OF THE CLINIC AT THE INSTITUTE FOR JUVENILE RESEARCH	31
V THE SOCIAL HISTORY	40
VI THE MEDICAL STUDY	54
VII THE PSYCHOLOGICAL EXAMINATION	81
VIII THE RECREATION STUDY	107
IX THE PSYCHIATRIC INTERVIEW	129
X SYNTHESIS AND PROGRAM OF THERAPY	148
PART III. THERAPY: ILLUSTRATIVE CASES	
XI PROBLEMS ARISING FROM INTERFERENCE WITH THE CHILD'S OPPORTUNITY TO GROW: CASE STUDIES	163
XII PROBLEMS ARISING FROM FAILURE TO SUPPORT THE CHILD'S DEPENDENCY: CASE STUDIES	179
XIII PROBLEMS ARISING FROM FAILURE OF PROPER DI- RECTION, TRAINING, OR CONTROL: CASE STUDIES	223
XIV PROBLEMS ARISING FROM THE CONSTITUTIONAL INADEQUACY OF THE CHILD	291
PART IV. THE CLINIC AND THE COMMUNITY	
XV THE RELATIONSHIP BETWEEN THE CLINIC AND THE COMMUNITY	321
PART V. PERSPECTIVE	
XVI PERSPECTIVE	335
BIBLIOGRAPHY	347
INDEX	355



PART I

THE PROBLEM OF CHILD GUIDANCE



## Chapter I

### NATURE AND NEED OF CHILDHOOD

CHILDHOOD has two major characteristics which to some extent are conflicting. It is a period of growth and preparation and it is a period of dependency. It is necessary in our thinking constantly to keep these two elements in proper balance in order to maintain a grasp of the significance of childhood and to protect our children from excesses occasioned by warped perspective. Over-emphasis upon a child's dependency is likely to result in too sentimental an attitude and in over-protection and over-babying. Absorption with the child's growth often leads to overlooking the importance of the support and guidance which adults should give the child. When coupled with traditional attitudes this absorption may result in too Spartan standards, or when it occurs in the atmosphere of the progressive school, in too complete laissez-faire. A child is not simply a small adult, nor should he be treated as one. On the other hand, certainly a consideration of childhood becomes unrealistic if one forgets that its end is adulthood and that it is brief when compared with the total span of life. Since it is a period of preparation, it is one of such constant change that generalizations about it are very difficult.

Many parents need repeatedly to be reminded of the fact that the child is a vital, growing, living individual, and not inert. From the moment of conception there is within the organism itself the tendency to become adult. Outside factors can favor, hinder, or prevent this growth but cannot possibly initiate it. Childhood is often erroneously described as plas-

tic. This is an extremely unfortunate symbol. The child is certainly not plastic in the real meaning of the term. The direction of his growth can be changed in astonishing ways and many potentialities can be destroyed, but he is always a reacting being. Always, when influences are brought to bear upon one aspect of the child's nature, reactions are set up in other fields. Always, to a greater or less extent, he responds as a whole to any situation. As a result, though the child will grow to be one sort of an adult if certain forces play upon his childhood or a very different adult if others come to bear, the finished product is a compromise between his innate tendencies and the various influences which bear in upon him; and the points of compromise are often points of strain and weakness in the adult personality.

Yet the innate tendency to growth and the results of various influences are so intimately bound up in one another that our present knowledge of the real inner tendencies of the child, is extremely meager. We know there are tendencies to physical growth and to changes in physiological processes which are to a considerable extent dependent upon glands of internal secretion. Even the physical tendencies are greatly modifiable by environmental conditions. We know also that there is a growth in intelligence. The psychologists tell us that they are able in some degree to measure this innate growth principle and to separate it from the results of environmental influences. When we come to a field which is as yet less subject to definition—that of personality—we are still attempting to analyze and to understand the actual innate tendencies to growth. We see in children a growing awareness of self and differentiation of self from surroundings, which is very largely the result of experience, but it seems not at all unlikely that there is also an inborn tendency in this direction. There is clearly a growth in the capacity to enter into intimate personal relationships with other peo-

ple, a tendency which probably exists independently of external stimulus. There is also independent of the individual experience of the child, although greatly modified by it, a growing wish to be a free agent. Beyond this we cannot be sure whether an observed trend within his personality is an expression of an innate tendency or the result of experience.

But childhood is also a period of dependency. When the child comes into the world, he is physically incompetent, utterly ignorant, and his will is limited to the urgencies of the immediate present. He has within him tremendous potentialities for growth but he is utterly helpless, and the notion that it is only necessary to allow his inner nature to unfold in order that he may reach a happy self-directed adulthood is preposterous. The child is in almost constant danger with which he himself is unable to cope, danger from disease and injury, danger of self-injury and self-destruction through venturesomeness, and more subtle but in the long run equally serious danger of failure to develop spontaneously certain of his potentialities which will be necessary to a well-rounded and successful adulthood. The capacity imaginatively to realize the future significance of present acts and to modify them accordingly is extremely weak in childhood. This is one factor in the inadequate self-control of the young child.

The needs of the child are a corollary of his nature and it is upon considering the needs that the conflict between the two outstanding characteristics of childhood become obvious. The child needs to grow to an independent being with adequate control of himself and of the situation in which he finds himself. At the same time, during growth to this goal, he should be protected from making irreparable mistakes. Control must be exercised but the object of control is to enable the child ultimately to get along without it. No rules can be laid down as to the point at which the exercise



of control tends to defeat the real purpose. It is our opinion that the prevailing tendency is to exercise too great and too prolonged control. It is very easy to forget the end and to become absorbed in the means. Yet control must be used. It must be used to promote physical health. Children do not spontaneously unfold into tooth brushers and cod liver oil drinkers. At times medicines have to be taken, often unpleasant ones. On the other hand, there is some evidence that if given the opportunity children do spontaneously become eaters of well-rounded and adequate diets.

The child also needs direction or control in his schooling. Children have an intense curiosity and if left to themselves would undoubtedly acquire an enormous amount of information and experience, but the product of self-acquisition alone would certainly be patchy and very inadequate to meet the demands of the complex culture in which our youngsters have to live. Something of a curriculum is necessary if the child is to acquire within the allotted time sufficient knowledge and skill to function effectively, and some planning is necessary if the child is to learn to get along with other people. A degree of adult control, therefore, must be exercised.

Before dismissing the notion that the ideal of an unfolding of the child's inner nature is utterly ridiculous, it should be said that behind this somewhat unfortunate sentimentality there is a truth which needs to be stressed. The young of the lower animals do not need parental control. They are able to unfold their inner natures and in a sufficient number of cases to reach maturity. This is because they have instincts, that is, inborn automatic responses to situations. The human infant in place of such instincts \* has an amazing

\* There has been criticism of the use of the word instinct here, for the untrained, adequate, and relatively complex responses to life situations seen in lower animals as contrasted with the necessity for training which



teachableness. Teachableness and instinct are diametrically opposed to one another. Instincts are very efficient labor saving devices, but they have one serious objection, namely, that the animal guided by instinct is often at a loss to meet new situations. If any step in the complicated interplay between the animal and his environment goes wrong, disaster results. Because human beings are so poorly equipped instinctually, they have been able to meet diverse circumstances with a flexibility incomparably greater than that of any other animal. But this flexibility is expensive in terms of thought and judgment and mankind has learned to spare them through the acquisition of certain automatisms and rules of conduct. These automatic predetermined responses to situations have very much the advantages and very much the disadvantages of instinct. The boy on the burning deck is an extreme example of the disadvantages. It is partly through the close control of the child by adults that the native flexibility is replaced by rigid and automatic responses. To lose this flexibility is to throw away one of the most precious of our human heritages. It is important (and frequently overlooked) that the child preserve to adulthood just as much as possible of the flexibility of response which he brings into the world.

How then is control to be exercised? In general the child will choose one type of conduct rather than another because the former appears to him to be more pleasant or less painful than the latter, and control of behavior can be achieved only through this means. For the parents the easiest way of making one course more desirable than another is to make the disfavored course result in unpleasantness. To make the desired course result in a pleasant experience requires more

is so characteristic of human beings. "Instinct" is used by different writers in widely differing ways. The word is used here in its biological sense.

ingenuity. Rewards and punishments are clearly the obverse and reverse of the medal and one method is not inherently to be preferred to another. Ill-advised use of rewards can be just as damaging to the child as ill-advised use of punishment. Parents too often forget that, by a little thought, they can frequently arrange things so that the desired course of action will of itself result in something pleasant for the child or the undesired course of action will of itself bring about punishment. And the more direct the relationship between the child's action and that which happens to him, the better for the child for two reasons: first, the lesson is more effectively taught in this way, and, second, the child learns that there is a practical reason for choosing one method rather than another, instead of learning that in some mysterious way a being wiser than himself knows exactly what he should or should not do. The former experience leaves the child free to meet new situations in new ways, whereas the latter tends to crystallize within him the parental conceptions. If possible, then, the situation should be arranged so that the child can see clearly the relationship between his activity and the reward or punishment that follows. For example, learning to read opens up to the child such a treasure house of delightful experience that a little ingenuity on the part of the parent or teacher can make this clear and no other incentive need be employed to enable the child to find the will to surmount the preliminary difficulties. On the other hand, the relationship between the pain of a series of diphtheria immunizations and the vague concept of "good health," is so obscure that a child at the age when these should be given cannot realize it. In this case an artificial reward, such as a trip to the zoo, is quite justified. Somewhat intermediate between bribery and direct reward growing out of the child's conduct is social recognition. Much the same considerations apply here as to other types of rewards. Social recognition

by the child's playmates is a vital, flexible thing, capable of growth and change, whereas social recognition by adults for achievement is likely to impose rigid adult standards on the child. To a large extent children can be relied upon to discipline one another.

Since human kind has a fondness for consistency, pattern, and order, ways of behaving carry over from one situation to a related situation, and as the child grows older he develops some framework of "standards." This framework when developed becomes an important factor in directing and controlling his behavior. This pattern of standards may be socially valuable or may be socially destructive.

This brings us to the most significant characteristic of all, which has not previously been mentioned because it applies to all human beings and is not confined to childhood. The child is a social being and always in a social setting. Without the setting he cannot be understood. Even when alone he is responding to social forces which have played upon him earlier. Usually the child is in a home, and through childhood and a large part of adolescence the home is the most significant of the social situations in which the youngster finds himself. Throughout life, and above all the other needs, there is always the need for relationships with others, for recognition, for love, for response in general, and often for rivalry.

## Chapter II

### THE EXISTENCE AND VARIETY OF PROBLEMS

**I**F a number of persons were asked the question, "What problems of child behavior do you believe merit study and treatment by a child guidance clinic?" wide differences of opinion would be evident. Some would regard certain personality characteristics or kinds of conduct as problems demanding specific attention, while others would pronounce them normal enough and propose different ones as more important. Seclusiveness might be mentioned as one of a number of traits about which there would be varied opinion. Some would regard this trait as a probable forewarning of serious mental disorder, while others would look upon it as the expression of a wholesome desire for occasional privacy.

The difference of opinion would be wider with respect to a trait in the abstract than it would be about that trait in a particular child, where could be seen the degree to which it has developed, its appearance in a particular kind of occasion, its present results, and perhaps its significance for that child's future development. Some might be inclined to judge the seriousness of the condition by the obviousness or persistence of the trait. It is true that these aspects of a trait are worth considering, especially to the extent that they let us know the significance of the trait—its relation to other aspects of the child's personality. In some children a trait is relatively superficial because it has been acquired largely through imitation, whereas in other children the trait has developed in relation to something deep within them.

Undoubtedly many persons have in mind the "average"

or "normal" child when they judge that a certain child presents a problem worthy of special study; they compare this child with the average, they find him different, and they conclude that this difference constitutes a problem. In their opinion any deviation from the usual state of things merits study at a child guidance clinic. This is erroneous.

Whether, for example, a mentally defective child should be referred to a clinic would depend upon how well he is being taken care of and trained at home, how adequately his condition is understood and accepted by his family, and how well he will be provided for in the future. He is not a problem if his care does not present a question. He is a problem if his parents or others see that his needs are not properly met in his present situation or cannot be met in the future. Perhaps his care and supervision are too burdensome or have become impossible, or there may be such questions as, "Can something be done to help him get along better?" "Are we doing the right thing for him?"

A child may exhibit severe temper tantrums or he may take money from his mother's purse, but, if the parents are able to appreciate the factors in this behavior and proceed soundly in dealing with the factors and with the behavior itself, there is no reason for them to call upon a clinic for advice. They might, however, wish to have the wisdom of their program confirmed.

Thus, deviations in status or trait or conduct do not necessarily constitute problems or do not always indicate a need for study by a child guidance clinic. A deviation in a child is properly brought to the attention of a clinic when it is not adequately understood or dealt with by the persons who are taking care of that child or when it is seen to cause present disharmony or to portend future harm or unhappiness and to be beyond the remedial resources of his immediate environment.



"Negativism" or the "no! no!" tendency to contrariness, found frequently in young children, may here be considered in its "problem" aspects. Many persons regard negativism as a transient but natural and hence unavoidable phase. Thus they would not consider it a deviation from normal, but might regard it as faulty behavior. Since in most children it passes soon, no lasting or serious, direct harm need be expected; but it does cause present disharmony (and in some cases this is marked) and it may indirectly lead to future trouble, hence it would be well to try to overcome it as soon as possible.

Some parents will be able to see this behavior in proper perspective and will understand its factors well enough to accomplish the desired result in good time. Others will not be able, unaided, to see the problem or its solution.

In many cases the child may really have less amiss in him than is amiss in those who deal with him. A child with a completely wholesome and even ideal personality (if one could ever be described) could be in such disharmony with certain things in his environment that he could be considered a problem from the private perspective of the family or the teacher or some other person dealing with him.

Some parents have very inadequate knowledge of child-nature; some are extremely over-anxious about some item of behavior in the child; some have, through their misgivings and expectations of wickedness in a child, so circumscribed him, so restricted him, or so severely dealt with him that he has rebelled or otherwise circumvented their efforts. Perhaps he has, without much thought, followed in his own way his interests and urges which were meeting general misunderstanding and thwarting at the hands of his parents. Or he may have thought out his position as one involving unfair restriction (as compared with his knowledge of other homes) and he may have marshalled his forces of opposition, may

have planned his battle strategy. And yet this child might have presented no difficulty whatsoever if he had been more thoroughly understood, more wisely handled.

On the other hand, children may have real problems which are not being recognized by those in his immediate environment; in such cases the problems are more likely to be ones which do not create present external disharmony but which may later lead to serious difficulty if not corrected.

A child guidance clinic has many cases referred to it in which the supposed "problem" lies only in quite wholesome behavior, but behavior which has been wrongly appraised by the parent, causing him to become anxious and to seek advice. A child of four may be refusing to take his afternoon nap, may be repeating vulgar language which he hears on the street, may be asking the mother where babies come from. Such behavior alarms the parents because some published authority or their own lack of familiarity with the normal zone of child behavior has led them to see it as harmful or as a threat of later enormity. When this state of things is suspected at the time an examination is requested, a clinic could quiet the parent's alarm and dissuade him from having the study made simply by saying that the child is behaving in a normal fashion and that there is nothing to be excited about. But this type of case often presents as real a disharmony as if the child's behavior were actually outside of the normal zone. That disharmony should be eliminated; the viewpoints of the parent which make it possible for innocuous behavior to be regarded as harmful or dangerous need to be changed. Furthermore, if this behavior, generally regarded as unharmed, causes enough concern to stir a parent to seek assistance, more serious behavior might lead to an extreme degree of tension within that home.

On the other hand, children are often referred for examination in relation to certain problems which have given

rise to parental anxiety but which are soon seen to be far less significant than other problems which are revealed through the history or the various examinations of the child, although these latter problems may have been passed over without concern by the parents. A child may be referred for examination because of retardation in school (a proper reason for requesting examination) yet much more important problems—his extreme jealousy of his younger, more attractive sister and his doubtful or unsatisfactory position in the affectional relationships of the home—may have gone unnoticed.

Every child has or causes some problems. Often these are merely expressions of the awkwardness of his growth in personality and in social adjustment, and these will later tend to disappear. Often they are the expression of a limited appreciation on the part of his parents of the normal zone of behavior or personality, and the parents may “catch up” in their knowledge and wisdom (as they often do in dealing with the second or third child after having made many mistakes with the first or second ones).

Frequently problems are seen to be related to certain traits or interests within a child which in one situation prove to be liabilities but which in another situation or with a slightly changed direction might prove to be assets. The “stubbornness” of some children may be an expression of originality in thinking and a strong desire to finish endeavors they have started.

That every child must be in some disharmony with his environment, at least from time to time, could be expected from the fact that various elements within himself are in some disharmony at least occasionally. These disharmonies range from the very simple, obvious ones (as his presumptive appetite for food versus his actual appetite for it—“his eyes are bigger than his stomach”) to the more subtle ones in



which one aspect of him conflicts with another (for example his sex interest stirs him toward contact with girls while another aspect of him, his loyalty to the tenets of his gang or to his mother who desires to keep him "just a child," holds him back from these contacts). There may be clashes among his various loyalties: his teacher, his friends, his parents; clashes among his interests: his school work and his play life; clashes among his values: honesty, truthfulness, comfort, pleasure. How then could he always function smoothly?

But while difficulties of adjustment are universal they do not all merit the same degree of concern or study. Nor would it surely be advisable to have all children brought to a child guidance clinic even if clinical facilities were multiplied a hundredfold. It is certainly conceivable that there are parents who understand their children well and know how to guide and train them and who are resourceful enough to meet any ordinary situation and even some extraordinarily difficult ones. A brief clinic contact with a child whose parents are so described would probably bring no hidden truth to the light; a number of contacts might unearth something or might bring certain elements into different emphasis or might add nothing of value.

The intensive study of children's problems has taught us much, but we still have a great deal more to learn. Obviously we can be of most help to a child who has problems of behavior or adjustment of a type about which we have fairly adequate knowledge. But the study of obscure and subtle problems, while it may not always directly and immediately help the child who has them, may build up an adequate understanding of these in the future. Among the problems brought to child guidance clinics some years ago were cases of retarded school progress on the part of children with good intelligence who were, however, slow in learning to read.

The analysis of the elements of reading difficulties and the development of skill in remedial tutoring for different reading disabilities had to await further opportunities to study such cases. Thus, while the problem children of this type who first came for study at the clinic may have been somewhat helped, the children with similar troubles who came later have profited to a larger extent from the understanding and experience gained through the pioneering work.

There are in any community many children with severely disturbing behavior for which the advice of a child guidance clinic is sought. Perhaps any clinic could be kept completely busy with the study and treatment of such problems. Even though this be true it must be remembered that in general the lesser disturbances, the milder problems, lend themselves better to thorough study and treatment and give an opportunity to see the present play of cause and effect. Often the children with the very severe problems are less accessible to study, and the causes often can merely be conjectured. Many of these children come to us with such a thoroughly defensive or evasive attitude, developed through the vigorous and personally adverse handling which they had received, that we cannot succeed in gaining their confidence or good will. Thus it is well for a clinic to have an opportunity to study a wide variety of problems, even those encountered during the pre-school years. These latter problems often seem insignificant, trifling, but many of these problems come from parental misconceptions, faulty attitudes, and wrong philosophies of child guidance which may persist and may give rise to much more serious problems later.

A sound philosophy of child guidance is applicable to children of any age. This philosophy considers the child as he is, his nature, his needs, the forces of his present environment, his capacity for growth and change, the ultimate development which should be aimed for (especially in regard

to good judgment, good tastes, wholesome attitudes, helpful interests, and good habits), and the best means to use in training. In general the best means are the positive ones which employ, direct, and cultivate things within the child rather than the negative procedures which attend pointedly, immediately, and aggressively to his present faults. If the parents of a preschool child can, through contact with a clinic, come to a development of a sound point of view with respect to the child-parent relationship and toward the aims of child guidance, they will be more likely to avoid difficulty in the child's later years.

A classification of conduct and personality and other problems for which a clinic could well be consulted will not be attempted here. However, a number of types of problems will be mentioned in order to indicate their range and variety.

They are named, not in terms of our diagnosis, but in terms of descriptions used by the persons who refer the children to us or as translated into more brief, generally accepted descriptive groupings. A parent might say that he wants us to examine his child because the child "doesn't learn much; he is slow in learning things" or "is very backward" or "hasn't good sense; acts like a child half his age." These we might translate into "unduly immature or childish manner or judgment" or into "mental retardation" or "question of mental retardation."

Among the simpler problems, although not necessarily the ones most amenable to treatment, are the habit problems, items or patterns of behavior which are frequently repeated. These include the body-manipulation habits, such as thumb-sucking, nail-biting, masturbation; the faulty elimination habits, as enuresis and soiling; the behavior patterns, as temper tantrums and negativism. These "simple" problems may have started from simple causes, but they are often found later to have acquired subtle significance and relation-

ship to things which are at first far from obvious. Often these problems are far-reaching in result because of the pressures of various sorts which have been put upon the child in order to eliminate them.

There are many problems which could be looked upon more as personality problems than conduct problems. They involve the inner processes and attitudes of the child rather than the comfort, convenience, and well being of persons around him. It should be stated, however, that most conduct problems to some extent are interwoven with personality problems which have either been factors in the conduct or have resulted from the conduct and from the pressures, external or internal, which the conduct has originated. There are children who have had, so far as any one could observe, nothing unusual in their personalities and who, after being involved for a period in disapproved behavior, have developed an apparently quite different personality. This has come about through the various influences resulting from the new rôles the children have assumed. Earlier complete or nearly complete allegiance to the family and its mores has suffered, conflicts between various desires within the children have developed, a new sense of the compelling realities is being built. In such cases children are treated differently because their conduct is not approved and then reactions to this treatment arise and may become somewhat fixed. Some personality problems such as shyness or excessive sensitiveness ordinarily do not lead to active conduct disorders, while other personality problems such as emotional instability, excessive distractability, and egocentricity often lead to difficult behavior.

Some personality problems which are frequently brought for study at a child guidance clinic are "nervousness," restlessness, overactivity, unduly immature or childish manner or judgment, excessive sensitiveness, shyness, timidity, over-



dependence, self-pity, excessive anxiety, widespread or intense fears, rebelliousness, irritability, selfishness, jealousy, emotional instability.

Some frequently encountered conduct problems are fighting, disobedience, temper displays, stubbornness, incorrigibility, destructiveness, stealing, lying, running away from home, truancy from school, excessive sex curiosity, various kinds of sex activities.

Other problems about which an opinion or advice is sought are many kinds of physical disorders or constitutional defects related to behavior (such as intellectual retardation, deafness or suspicion of deafness, convulsive seizures, chorea), educational and vocational problems (such as retardation in school, question of poor school work in spite of good intelligence, lack of interest in school work, question of proper grade placement, inability to learn to read, question of the type of school courses to meet the needs and abilities of a child), problems of proper type of placement (such as would be expressed by the following types of questions: Should he continue to live with his parents or be placed elsewhere? Should he be placed in a foster home? What type of foster home? Should he be placed in an institution? What type or which one? Should he be adopted or would it be best to advise against this?).

## Chapter III

### THE CHILD GUIDANCE APPROACH

**A**DJUSTMENT is by definition a relationship. It is impossible to consider the adjustment of a child except with reference to a specific environment. The solution of a maladjustment is therefore theoretically possible through the modification of either the child or the environment, or both. Commonly we must make the choice between seeking to mold the child to fit the environment or seeking to mold the environment to fit the child, or perhaps seeking to accomplish both of these changes.

While we hold in general that the Sabbath was made for man, and not man for the Sabbath, and that there is nothing sacred in social organization other than the contribution it is able to make toward human welfare and happiness, nevertheless we are forced to recognize that it is not within our power to remake society to fit the personality of every child. Indeed the control we are able to exert over the environment of a child in the community is brief and precarious at best. There is, under the circumstances, little kindness in modifying the environment to fit the child if this temporary modification does not equip the child better to pick his way without disaster among the unpadded realities of social life. If modifying the environment to fit his personality makes him less capable of adjusting to the environment he must meet in the future, it is a disservice, as any layman with common sense knows.

The choice between the child and the environment as a point of attack must be decided in each individual case, and

many factors may enter into the decision. One of the most important will be an estimate of the accessibility of the child and of the environment to modification. Another will be the deviation of each from what is regarded as normal, standards of which will vary from community to community even in the same city. These questions will be considered more fully elsewhere.

Even though maladjustment is by necessity a relationship between a particular child and a particular environment, it is convenient in our thinking to locate the cause in some cases in one sphere or the other. There are children who cannot be expected to adjust satisfactorily in any "normal" environment, and there are environments to which no "normal" child can be expected to adjust.

The group of children who cannot be expected to adjust to any "normal" environment is, of course, composed of children who are handicapped. In general the physical handicaps are not insuperable. Blind children, deaf children, children with limbs amputated often adjust surprisingly well and lead apparently happy lives. When, however, there is damage to the brain, to the organ of adaptation of behavior itself, the child is often totally incapable of adjusting to any environment available in the community. Three important classes of deficiency should be recognized here. One is defect of the intellectual faculties, which may be ascribed to injury, maldevelopment or dysfunction of the cerebral cortex. Another is disorder of impulse which is most clearly exemplified in some children suffering from the disease lethargic encephalitis. There are furthermore some children, who despite normal intelligence and despite the absence of any signs of organic brain disease, are unable to adjust to any "normal" environment. This group includes children who are psychotic, and children who, whether by reason of innate

nature or the impingement of a morbid situation, have developed psychopathic personalities.

Valuable techniques are available for the measurement of the intellectual faculties, and this field will be considered in some detail in Chapter VII. The disorders of impulse which frequently accompany lethargic encephalitis will be given further consideration in a later chapter. Examples of each class are included in the section on therapy.

The environments to which no "normal" child can be expected to adjust include those extremely bad home situations in which a child is directly trained in delinquency or is so thoroughly mishandled that as a rule it will be evident to any one that he cannot be expected in such surroundings to develop normally. This latter situation may, for instance, occur if one parent is insane or has a morbid personality. If a family environment is so unfavorable that no normal child could be expected to adjust to it, attempts to modify it adequately will probably be fruitless. In such cases removal of the child from the home through the intervention of the court, if necessary, will usually be the only possible solution.

There are numerous therapeutic tools which may be suitable for an attack on a child's problem directly through the child. A therapeutic effort to modify the child may be made through medical treatment in instances where some correctable physical disorder or condition appears to play a rôle in the production of the maladjustment. This may involve direct medical treatment for a disorder of the nervous system, such as the use of luminal or bromides to hold in check epileptic seizures. It may include seeking to modify the individual by correcting a visual handicap with spectacles or by treatment designed to overcome hearing defect. It may involve improvement of the child's general health through, for example, the requirement of a daily rest period in a young child.



It may involve diminishing a physical annoyance, as by the treatment of an itching eruption. It will occasionally involve administration of some hormone deficiency in the body economy as in thyroid deficiency. It may often seek to correct a defect in appearance, such as a harelip or skin disorder. It may often seek some accomplishment through the removal of chronic foci of infection. Physical training may be enlisted in the service of child guidance to overcome physical defects or to develop in a child with inferiority feelings some added degree of physical achievement so that he might thereby gain recognition by his fellows.

Special tutoring may be of value in overcoming specific handicaps in speech, reading, writing, spelling, or arithmetic.

Psychotherapy directed toward the child may be used in an effort to modify the child's attitudes, to assist him to work out emotional conflicts, and to attain a more adult and mature attitude toward situations and individuals with whom he comes in contact. Such changes may be reflected in his behavior and make his adjustment easier.

The division between therapeutic efforts to modify the child directly and efforts to modify him through the environment is of course an arbitrary one. The therapist is after all a part of the environment of the child and it is sometimes difficult to determine whether he is influencing the child directly or whether he is influencing the child indirectly through the medium of some element of the environment other than himself.

The main weapons for a therapeutic attack upon the environment in the effort so to modify it as to aid adjustment of the child may be grouped in two categories. One is the removal of the child to new surroundings, the other, modification of the surroundings in which the patient is already placed. The most important elements of the surroundings are, of course, the personalities with whom the child comes

in contact. From the standpoint of child guidance it will usually be less of a change of surroundings for a child to be moved to a new city but remain as a part of the family group, than for him to remain with some adult at an address where he has been living while the rest of the family group moves elsewhere. The placement of a child in new surroundings is in itself a matter of varying degree. One of the more complete changes is that of placing the child in a foster home or an institution. These procedures are necessary when it is apparent that there is no reasonable likelihood that the home can be so modified as to make it adequate. They may be of value to give child and parent a temporary rest or vacation from each other in which to work out a new plan of meeting the situation. Such a temporary complete change is that of sending the child to a summer camp for a few weeks. An incomplete change may be made through having the child entered into a recreation group, athletic group, or some type of neighborhood center activity.

The number of instances in which a complete change of surroundings can be made is necessarily at present very limited, chiefly for economic reasons. In most instances the surroundings must be modified rather than changed. This may be done by advice and psychotherapy directed toward the child's parents. In certain cases the help of the siblings may be enlisted in treatment. The most important community agency in contact with the child is, of course, the school, and a favorable relationship with the school is very important for the success of any child guidance agency. It is necessary to remember that in most public schools classes are large and the opportunity for teachers to give individual attention is limited. Their coöperation, however, can usually be secured by any one with an apparent grasp of the problems of a child and a readiness to consider them with the teacher in relation to the entire school situation.

Often a recreation leader can be enlisted to aid a child in making a social adjustment in a play group. Sometimes it is possible and advantageous to enlist the aid of a whole group of children with whom a particular child plays.

It is possible to cite an indefinite number of other individuals and groups who come in contact with the child. One group of importance for their contact with and influence on children are the clergy.

Religious instruction is not conceived as one of the functions of a child guidance clinic, nor is the approach of the child guidance clinic toward the problems of conduct the primarily moralistic one so usual to the clergy. When, however, as is often the case, the religious counselor of a family is interested in considering the behavior of the child in question in terms of cause and effect and also realizes the practical limitations of the moralistic approach in modifying the child's conduct and the possible dangers involved in this approach, his coöperation may be very valuable. His aid may be important in winning the confidence of and in changing the attitude of the parents. The personnel of a child guidance clinic should remember that here is the potential resource of a large body of professional individuals who are also concerned with problems of conduct.

The effort to modify the behavior of individuals toward a child may be divided into convenient categories of advice and psychotherapy. There is no sharp dividing line between these categories, but the classification is useful. For instance, a mother may mismanage her child through ignorance of what should be done. She may be capable of faithfully carrying out any directions which may be given her on the management of a child. Such a mother merely needs advice. On the other hand, a mother may be emotionally unable to behave toward her child properly or to recognize fault in her be-

havior when it is pointed out. The "over-protective" mother is a common example. For such a mother advice of course is inadequate. Her conduct can only be modified through producing a modification of her attitude. She cannot be effectively *told* how she should *feel*. Her own emotional problems must be solved to the extent of finding another way of satisfying her emotional needs if anything is to be accomplished. This is psychotherapy. Another mother, more objective than the last, may know perfectly well where she had made a mistake in the management of her child and yet because of problems of her own be emotionally unable to modify adequately her conduct in this particular. Such a mother is but little benefited by advice, but she also can perhaps be benefited through psychotherapy.

It goes without saying that the attitudes of parents (or other individuals important in the life of a maladjusted child) can at best be much modified only under favorable circumstances. Primary requisites are a desire on the part of the parents that their attitude should be modified—or at least a desire to learn how to manage the child so that he will behave and develop properly—and a willingness to make an active and sincere effort to understand themselves.

Many parents come to a child guidance clinic because of pressure exerted by school authorities, a social agency, or the Juvenile Court. Such parents are apt to approach the clinic with a hostile and uncoöperative attitude. This can frequently be dispelled by an explanation of the nature and purpose of the clinic. If a tactful and reasonable effort to bring them to a coöperative attitude fails, an effort to work with them or to modify the behavior of a young child under their control is almost inevitably fruitless. In general it is a waste of time for a child guidance clinic to concern itself with the problems of children whose parents cannot be

brought to a genuinely coöperative attitude.\* When the problem is so serious in the eyes of the community as to justify the intervention of a court and the removal of the child from the home, the situation is thereby changed and effort may prove productive.

\*Possible exceptions to this rule include certain cases of intelligent adolescents who can be aided to understand their parents and make allowance for them.



PART II

THE DIAGNOSTIC STUDY





## Chapter IV

### ORGANIZATION OF THE CLINIC AT THE INSTITUTE FOR JUVENILE RESEARCH

**A**LTHOUGH there are appreciable differences in the structure and procedure of various child guidance clinics, we shall confine our discussion in this chapter to the Institute for Juvenile Research in Chicago.

Children may be referred to the Institute clinic by any individual or organization or by a chain of persons. The various individuals concerned with the initial contact with the clinic may, therefore, regard the examination from very different angles and these differences of viewpoint may result in misunderstanding and confusion and interfere with the usefulness of the clinic service unless the staff plans each step with care and forethought. For example, from the point of view of the truant officer, examination at the Institute may represent an effort to help a "bad little boy" who is causing a total upset of discipline in the fifth grade; from the point of view of the parents it may represent the singling out of their child from many similar "bad little boys" to subject him unnecessarily and unjustly to scrutiny; while from the point of view of the child the examination may represent punishment. In another case a scholarship association may send a child to the clinic to be advised wisely about his further education, but the child may regard this examination as a test upon which depend his ultimate and absolute success or failure in the world. The clinic must act wisely and with foresight to minimize the risks of any unhappy experience either to the child or to the parents.

There are three ways in which the Institute learns that its help is desired in a case: (1.) The parent or a friend may arrive at the door, bringing the child. (2.) Parent or friend may arrive to talk over the situation, but without the child. (3.) The referring individual or agency may telephone or write asking for an appointment.

An application blank is given to those seeking examination of children, together with a sheet of mimeographed instructions for applicants. When the parent appears in person, a brief interview with a social worker is arranged, and if the child is brought he is seen briefly by a physician. These precautions are to make sure that no emergency situation is overlooked.

The Institute is an organization supported by the tax payers of Illinois and as such its services are available to all persons living in Illinois. For many years there have been more applications for examinations than the Institute has been able to meet promptly. For many years there has been a waiting list. However, if there were no more plan in the making of appointments than a system of first come, first served, many treatable children suffering serious maladjustments would be neglected in order to make possible the examination of trivial or unpromising cases in order of their application. The Institute has established, therefore, a committee on applications, made up of representatives of clinical departments, which meets daily, reviews the applications which have come in during the week, and makes decisions as to the kind of examinations advisable for the case and the relative need for emergency service. Cases may be assigned through this committee to regular, special, summary, or routine service, which will be described in the following pages.

Before proceeding to a consideration of the nature of these services it is desirable to give the reader some under-

standing of the different clinical departments or disciplines in the Institute. These are social service, clinical psychology, recreation, pediatrics, and psychiatry.\* The reader may be interested in knowing something of the training of workers in these various departments and something of the background of the various professional fields represented in the clinic.

The psychiatric social worker is a case worker who has had special training and experience in relation to problems of behavior and personality. In its origin case work itself was primarily charitable and philanthropic in nature, but has gradually developed a more scientific and educative approach to social problems. Within the last twenty-five years certain specializations have developed within the field of social case-work, usually in terms of the various settings in which social work has been practiced, such as the hospital, the court, and the school. Thus psychiatric social work is that branch of social work which has developed in relation to psychiatry. This development has been comparatively recent and may be dated from 1905 when, for the first time in this country, a social worker was employed to assist in the care of patients with nervous and mental disorders in the Neurological Clinic of the Massachusetts General Hospital in Boston. The term, psychiatric social worker, did not come into use until about 1918 when the effects of the World War and the development of the mental hygiene movement stimulated a demand for trained workers in this field. At present the membership in the American Association of Psychiatric Social Workers numbers about 500. Standards of training involve college education followed by a specialized course in a professional school of social work, usually of about two years' duration. This

\* The Institute has also a sociological department but this functions chiefly with relation to the Area Projects, which will be described later and but little with respect to the clinic set-up.

course includes supervised field work in a psychiatric agency. It is the function of the psychiatric social worker in the child guidance clinic to secure the social history, to participate in the evaluation of the clinic findings and in the making of recommendations, to know and make available community resources for treatment, and to facilitate close working relationships between the clinic and other social agencies. In certain cases, which, after the initial examination, require further social investigation or treatment, the social worker may observe directly the situation in the home, the school, on the playground, or elsewhere and may, in consultation with other members of the clinic staff, carry on social treatment.

The chief duty of the clinical psychologist is the evaluation of the child's abilities and disabilities. He seeks to determine the actual level of the child's intellect at the time the case is referred to the Institute as well as his potentialities for intellectual development. He endeavors to ascertain his actual and his possible school achievement as well as his particular vocational aptitudes. The psychologist is expected to make an analysis of any particular difficulty the child may show in mastering the work of the regular school grades and make suggestions for corrections of such difficulties.

The minimum academic requirement for the position of the clinical psychologist is a master's degree in psychology, which necessitates much work along clinical lines. He must also have had at least one year's experience in supervised clinical work. The psychologists are the members of the clinic staff who are best acquainted with the educational resources and school situations of the community.

The recreation service at the Institute is unique. It may be regarded as an offshoot of social service. Its personnel is trained in social service. The department is regarded not as a separate professional field but as a temporary specialization, the justification for which is its usefulness in bringing



into proper emphasis the diagnostic value of the study of recreation and the therapeutic value of suitable recreation programs. The social workers of the recreation department are most closely in touch with group work and the resources of the community in this field. The training is similar to that for social work except that the emphasis in group work and in recreation fields is greater.

Many child guidance clinics, like the Institute, make use of the services of a pediatrician (a physician specializing in the care of children) for their physical examination and for the interpretation of the significance of the physical problems. In other child guidance clinics all physical examinations are made by the psychiatrist or by a general practitioner. At the Institute in the service for children of preschool age a pediatrician assumes responsibility for the evaluation of training, management, parent-child relationships, or other environmental or emotional factors in the substrate of the problem, and for the counseling of parents.

The fifth member of the staff is the psychiatrist. Psychiatry is a medical specialty. In addition to general medical and hospital experience, the psychiatrist's background training includes work in a hospital for the mentally ill. The understanding of human problems and of emotional conflicts gained through this background has been found to be of wide value in meeting the problems of emotionally maladjusted and even of essentially normal people. In addition to this training the psychiatrist needs experience as a fellow in some child guidance clinic in order that he may develop familiarity with children and children's behavior and in order that he may develop a full appreciation of the contribution which the other members of the staff can give. Most medically trained men also require some training and experience in a coöperative attack on problems in order to work comfortably with workers who have not a medical

background. The psychiatrist's training is calculated to give him an understanding of both the physical and social factors which enter into behavior problems of children and on this account he serves as the chairman of the staff and is the coördinator of staff efforts.

We may now return to a description of the types of service that have been listed as they exist at present.\*

### Full Clinic Service

Full clinic service includes a detailed social history and physical, psychological, and psychiatric examination, and, where needed, a recreation interview. There is a waiting list only long enough to insure the filling of vacancies which may be made available by canceled appointments. Cases are selected for this service on the basis of the following criteria: (1.) The condition is apparently treatable. (2.) Resources seem available for treatment and the carrying out of recommendations. (3.) The problem is apparently an important one to the community. (4.) A full study appears necessary for a proper treatment of the case.

Analogous to full clinic service is the *Preschool Service*. The organization of this service is identical with that of full clinic service except that a pediatrician functions in place of a psychiatrist. It has been considered appropriate, for reasons of liaison with the large body of pediatricians and general practitioners who treat children, to have a pediatrician working in the clinic with behavior problems such as beset pediatricians and general practitioners in private practice. Problems considered especially suitable for preschool service are problems of habit-training and management of young children whose parents have no deep-lying emotional problem

\* Since this manuscript went to press the services as described here have been combined under a plan entitled "Diagnostic and Admitting Service, and in addition, "Special Therapeutic Service." The change is one of mechanics rather than one of philosophy.



which stands in the way of their profiting by direct advice. Consultation with a staff psychiatrist or actual transference of the case to a psychiatrist is always possible when the child or his parents are found to need more specifically psychiatric study and treatment.

### Special Service

In special service the history is usually less detailed and the examination briefer than in regular service. The waiting list is short and space is reserved for emergency appointments. This service is also open to a fixed number of cases which are chosen on the basis of the first three of the criteria listed above. The third criterion, indicating that the problem is an urgent one from a community standpoint, is usually the selective one. Special service has been found to be a relatively useful service in which to examine children who present problems of mental deficiency, simple placement, or suitability for adoption.

### Summary Service

In summary service, also, the examinations are made reasonably promptly. The first three criteria listed above are again the basis for the selection of cases with the addition of one other criterion, namely, that an immediate examination procedure in certain fields of study is apparently adequate to meet the emergency problem and that a relatively informal handling of the case will best meet its needs. Other examinations may then be scheduled at a later date if the first examiners see any indication that they are desirable. The case of a child with a reading disability and no other apparent problem, for whom tutoring can be provided, and the case of a child with an emergency placement problem may be cited as cases particularly suitable for summary service.

### Routine Service

Into routine service fall all cases which remain when the quotas of the three selective services have been filled. It necessarily has a comparatively long waiting list. Children examined in this service receive those examinations which seem specifically indicated.

The staff examiners should have at the time of examination as much of the accumulated knowledge of the family and of the child as is possible. In a large city in which the social resources are organized, much information may be available. From the time of initial contact until the time of the actual examination, the Institute social service works toward drawing this material together. The case is cleared through the social registration bureau to learn whether other agencies have known this family. Often supplementary information is secured from other agencies over the telephone or by personal interview. The school may be asked to give a report of both academic progress and social adjustment. Often a family physician who has known the family for years and who is mentioned in the application blank can give information of value and can furnish a keen insight into the family weaknesses and strength. Information cannot be collected blindly and often the social worker has to draw a fine distinction as to when she may act alone and when only with the permission or with the aid of the family. Her aim is to make vivid to the staff the patient's past in its relation to the present problems.

When the social worker's preliminary report is drawn together, further contact with the child and the family is planned. These appointment plans are made by the clinic manager, who later, on the appointment day, meets the child and arranges for the examination program. This involves a schedule arranged as far as possible so that the appointments

of all children who come to the clinic on a given day dovetail properly, so that no child is over-fatigued, so that each child has short rest periods between examinations, so that no young child is kept at the office beyond his usual rest period, and so that the time of the examination staff is kept continually occupied. For the effective functioning of any type of clinic the good will of the patient and his approval of the clinic set-up and atmosphere are important. This is especially true for the functioning of a child guidance clinic. An informal, congenial, non-hurried attitude in the clinic office, and a well-equipped, well-supervised playroom are essentials of treatment.

It is important also that those most concerned with the child's welfare really understand the sequence of events in a clinic examination and the reasons for the procedure. Questions must be answered and doubts allayed as they arise. A next step, such as the sending of a written report following the examination, while clear to the staff, is often not understood by the parents unless explained. In the general examination procedure, flexibility is needed in order that the staff gain any true picture of the child. There is always the handicap of seeing the child in a setting that is alien to him. The examining room has, at the same time, the advantages of quiet remoteness, comfort, and lack of interruptions. If the social work preliminary to the examination has been successful, the social worker's report should bring into the sequestered atmosphere of the examining room a vivid, kaleidoscopic picture of the child living with his associates and in his home, a live picture of the community in which he has grown and developed and to which he has reacted. If the clinic management has been successful the patient enters the examining room at ease, without fear, and without fatigue.

## Chapter V

### THE SOCIAL HISTORY

THE social case history supplies to the clinic staff a revealing story of the child and his social setting. The plot centers around his difficulties, which often come about through friction between his growth process and the demands of his environment. It is evident that whatever affects this growth process or the environment is of significance in the story.

The causes of behavior disorders are manifold. They often reach into the past, to early childhood or infancy or even into the earlier lives of the parents. They often exist only in the immediate present. Clara Bassett, with the following quotation from the Final Report of the Commission on Medical Education (*Mental Hygiene in the Community*, Chapter II, page 42), stresses the need for a complete study of causes:

. . . a glance at the cross section of a patient's life will often be misleading. It is necessary to study the life of the individual and to determine the factors—hereditary, environmental, developmental, educational, economic, psychological, and emotional—which have contributed to the present problem and which may be important in diagnosis and treatment. The fact must be borne in mind constantly that a large proportion of the problems of patients are as yet unlabeled by science and have their origin in economic, social, and historic conditions.

Therefore, it is necessary in taking a history to spread a wide net to catch all the factors which may have a bearing

on the situation. It is proposed in this chapter to discuss the material which is gathered into the net, the procedures for gathering the material, and such sorting processes as are involved in the use of an outline and in the process of interviewing. We shall also concern ourselves with the trends and the changes in procedure that have come about through a growing understanding of child guidance work and a broadening concept of its purposes.

First consideration will be given the common sources of social data and the methods by which the material is made available to the clinic.

Some of the children who come to a child guidance clinic are referred by coöperating agencies whose personnel prepare the social histories. Workers in these agencies, in the preparation of a social history, draw data not only from the factual material in their records but also from their personal observation of the client, and from the responses they secure in direct questioning. Often the agency worker will have in her record all of the material that is needed for a child guidance examination. In some cases, however, a supplementary interview with the parent may be needed to fill in the gaps.

Social agencies are becoming increasingly aware that the material which is needed by the clinic in its study of the child is the same material which is needed in their own work. The trend, therefore, has been toward a closer relationship between the referring agencies and the clinic. It is now generally recognized that the agency referring the child is in a better position to secure the complete social information than is the clinic social worker. Occasionally it seems desirable for the latter to obtain supplementary information.

In addition to those referred to a child guidance clinic by social agencies there are many without agency contacts. From these the worker in the clinic gathers all the social



material for the clinic study. This material is secured through interviews with individuals and supplemented by information from such sources as schools, physicians, and hospitals. It sometimes happens that the social worker relies entirely upon material that comes spontaneously in the course of the interview. Such material may later be checked with that received from other sources, but discretion is needed in approaching these other sources when inquiry might bring results detrimental to the child or his parents. For instance, an inquiry directed to a teacher who is uninformed about the purposes of a child guidance clinic might be misunderstood and by focusing her attention on the child might add to the problem. It is an accepted practice now not to see informants such as relatives, teachers, or even other members of the family, without consent of the client with whom we are working.

The social worker in the child guidance clinic is aware that the child comes to the clinic out of an eventful past and a significant present. He comes as a stranger, except for the history which may enable the examiner to envisage this past and present. In taking a good history she must aid the members of the clinic to see the child from his earliest life, the preparation for his arrival, his birth, his reception, and the care he has had. A portrayal of the gradual broadening of his contacts and of the influence these have had on him provides a background which makes it easier for the examiners to feel that they have lived with the child and can see things as he sees them.

The causes of difficulties are extremely varied. Causative factors are often of a subtle nature, reaching even into parental attitudes established long before the child was born. It is important, therefore, to get a clear picture of these factors and to know exactly how the child is affected by them. Concrete details are necessary in order to make the child's

behavior actually live before one, but in spite of this the social history is no longer as exhaustive or as systematic as it once was. It becomes an interpretation of stresses and a collection of significant material rather than a complete record.

There is less emphasis now on searching for objective facts, since the individual's attitude toward these facts is of chief importance. For example, the verification of an adoption date may be in many instances of less importance than is a knowledge of the motives prompting the parents to adopt the child or the child's reaction to the knowledge of the adoption. It is important to know not only how these facts appear at the moment to the individual who is being interviewed but also how they appear to persons in his environment, and to note what discrepancies occur. For example, the child may report that he thinks his father does not love him or discriminates unjustly against him, whereas the mother may report that the father prefers this child to the other children.

The history traces the gradual development of those feelings and attitudes which evolve from a social situation; it discloses the basis, in many instances a quite valid one, for these feelings and attitudes. The history may reveal or suggest that certain behavior of an individual has for him a purpose or psychological value which might be far from obvious to the informant. Such would be the case of a child who develops a feeding problem and finds this very useful in gaining his mother's attention, which he has been unable to gain by any other means.

The primary requirement of a good history is a vivid description of the difficulty itself. One of the first steps that a social worker takes is an attempt to find out what the child's situation was at the time of the origin of the difficulty. The social worker is concerned with discovering any events in the external circumstances of the child's life which coincide in



time with the onset of the difficulty. It is often disclosed that a child has begun to present a problem at the time that there has been some event, perhaps a new "blessed event," in his environment. Its significance to the child or its possible causal relationship to his difficult behavior may not have been appreciated by his family. The social worker wants to know all she can learn about his intimate emotional background; this can become very complicated in some instances, such as a great number of changes in home situations.

The worker is enabled to define more clearly the real, underlying attitudes of the various members of the family toward the child as she observes these repeating themselves. For example, the social worker may suspect that the father dislikes or rejects his child in spite of a statement which contradicts this. She might find that at the time of the birth of his daughter the father was extremely disappointed that he did not get the boy he wanted, that he paid very little attention to the child during her infancy, that he has no time for her now, and that he showers gifts on the older brother whom he characterizes as his "pal."

The social worker should form such opinions only on further evidence developed in taking the history. Evidence to support opinion is taken not only from definite statements but from chance remarks that the informant makes or little incidents that are told. Slips of the tongue, the manner of giving information, the juxtaposition of remarks, and the observable tensions incidental to certain disclosures constitute a few "straws which point the way the wind blows." These things tend to confirm or disprove impressions which the social worker already has and they are therefore important in reconstructing the whole situation.

Consideration will now be given to the methods of organizing the conglomerate array of facts, conclusions, and impressions which the social worker has gathered. The material

which is selected, its organization, and its interpretation, depend upon her sensitivity to certain data, her point of view, and her training. Moreover, there are increasing evidences in case work that the relationship between the worker and the client determines the content and form of the history.

The trend is away from the idea of adherence to a definite outline. There is a tendency to dispense entirely with a preconceived idea of the material to be covered, as this may influence the dynamic relationship between the worker and the individual. The use of an outline may make it impossible to give a real picture of the individual; every heading may be covered without achieving much more than a superficial description of behavior problems. Therefore, the social worker tries, when talking to an informant, to keep her mind active with reference to the point—"What is this all about? What is the trouble?" The details themselves must not be regarded as final goals of inquiry but must be considered as parts of a much larger whole. If they are not so considered one may neglect to associate things that are of great importance.

When using an outline and assuming the questioning rôle, the worker places herself in a dominant position, which may thwart the development of a coöperative relationship. In her preoccupation with the outline she may not only interfere with the spontaneous flow of the individual's story but also waste time in following leads that get her nowhere.

In trying to discover what is in the informant's mind, the inquirer's random questions may be confusing. The informant adds importance to questions because they have been asked and may give a great deal of detailed information which has no bearing on the problem. It is also important to be sure that the informant really understands the worker's questions.

Treatment starts with the first interview, and the way the client reacts to giving information may determine in part the

pattern of his whole treatment response. Allowing the individual to give his own information without too much questioning permits him to set his pattern. If he cannot do this for himself, he may need the help of specific questions. The amount of help needed may be a measure of his dependence; it indicates to a degree the type of treatment that will be needed. It is only when the spontaneous giving of pertinent information by the individual has ceased that the worker should resort to questions. In some situations in which the informant needs considerable aid the outline can be used as a tool in making him feel that he is helping in the preparation for the joint working out of therapy. For instance, the social worker might say to the person being interviewed, "In order that the examination can be of service to you in understanding your child, it is necessary to know all we can about him. The outline we have here helps us in getting the information which child guidance clinics find valuable."

If the outline were dispensed with in every instance, it would be difficult to know whether the history was well balanced or unduly influenced by the mental set of the worker or overburdened by the trend of thought present at the moment. Again, important items might be overlooked entirely because the interest has been focused too exclusively on other more outstanding and intriguing features.

It is probably wise for the beginning social worker or student to depend upon the aid of an outline in reconstructing the individual's past, as considerable case work experience is required to train social workers and students to become aware of the variety of factors entering into diverse personality patterns.

Having learned the content of the outline, however, one may feel free to forget the form. As the content becomes a part of the planned procedure of the social worker she even-

tually becomes less and less conscious of the form itself. She knows when and where to omit material and has a plan formulated for later catching material omitted if it assumes significance in the treatment relationship. Virginia P. Robinson \* in *A Changing Psychology in Social Case Work* states:

It seems to me we are struggling in a confusion between *knowledge* of the present situation which carries necessary diagnostic and prognostic value and *history* of the individual's past which has value in building up our general understanding of conditioning experience but carries no meaning for treatment in the present problem. . . .

If and when we accept this distinction, we shall be concerned, in the early contacts, with obtaining as full and complete knowledge as possible of the present situation of each individual in his relationships with all the elements in his environment which have emotional significance for him. . . .

If this distinction is accepted, *history* † will not be needed to bulwark our uncertainty or to substitute for our ignorance of present reactions. *History* † will take its place in the relationship not in terms of the case worker's need but as one of the client's reactions. It will come into the record at whatever time and place the client needs to make use of it and his uses of it will be many and various as the relationship proceeds.

We have tried to emphasize the fact that the outline has been planned for the use of workers who are skilled enough to recognize that no outline can cover every type of problem that might arise. Such workers know when they may disregard the part of the outline that is assumed to cover the problem in favor of the dynamic aspects of the interview.

Particularly interesting are the methods of approach as they are used in the interview.

The social worker's underlying responsibility to the individual seeking help is to render suitable and timely service,

\* See Bibliography. Pp. 140, 143.

† Italics ours.



and she must be able to adapt methods and techniques to meet the individual's requirements. In no place is there a greater need for flexibility of approach than in the first interview.

The following are approaches frequently employed. Attention may be focused on the present situation, bringing out what has been significant to the individual, what he has done about it, what he plans to do about it, and how much, if anything, he is able to do about it.

In another instance the social worker and the informant may spend the time of the first interview in becoming acquainted. To spend perhaps an hour with the informant in her first visit to the clinic without proceeding to elicit information about the problems themselves might seem at first glance a woeful bit of negligence or an evidence of the ineptness of the social worker, but in some cases this is unquestionably the more sound approach. In this method of approach attention is focused on what the individual desires from the clinic and whether or not the clinic can fulfil these expectations, as he may wish something that the agency cannot furnish. In this situation the social worker must be secure enough so that she does not have the urge to "sell" a plan for study and treatment to an individual who neither wants it nor is able to profit from it. It is, therefore, worth while to know if the individual and the agency are "speaking the same language."

Another frequent approach may be a participation of the social worker and the individual in pointing up a background history. Where the client has an appreciation of the use to which such information will be put and of the value of background material to the total study, this approach may be effectively employed.

The response of the individual in the interview situation is obviously of great importance. The response is to a large

extent dependent upon the rapport which will be established between the social worker and the informant. Often the social worker using every device at her disposal and manifesting an attitude of helpfulness and interest is still unable to gain the confidence, ready coöperation, and good will of the informant. However, the degree to which rapport can be established between the client and the social worker determines the completeness of the history. The worker does not precipitate the confidences. Often if she does no more than listen and maintain a non-judgmental attitude she has served as a therapeutic agent in permitting the client a "release." The informant who "has a need to tell" presents no task from the point of view of questioning; rather the social worker may need to use caution lest the client reveal too much material prematurely and later may be troubled about having talked too freely. He may then in subsequent interviews definitely withhold pertinent data.

In interviewing informants who are protective, the worker must recognize that unless the material is willingly revealed to her she is limited in learning of the individual's problem. She can make an unobtrusive inquiry into the material which the individual brings forth. If she asks direct questions and presses the informant for material which is not given willingly the worker is able to note the evasions and sometimes find out contradictions in the material. If pressed too hard the informant may physically take flight or if he returns he may fabricate and the social worker will then secure an inaccurate, though detailed, history. If the informant is pressed to give information which he may not wish to reveal he may become hostile and withhold his full coöperation because of his hostility.

Then there is the possibility that the informant may develop negative feelings toward the worker and these result in efforts to defeat her. When various points and suggestions



have been made by the worker the informant may say, "I have tried that and it didn't work." By respecting protective reactions the social worker can help the informant to feel free to give information on the level on which he can give it. The individual is not always able spontaneously to articulate a basic definition of the problem. He can, however, tell what is on his mind and thereby furnish leads for inquiry by the social worker into what he has already revealed. If the social worker listens and observes she may become aware of many things that are not actually expressed in words. The informant's manner of talking and the attitudes he betrays may disclose to the worker things which contradict what has been said.

There are also individuals who react defensively and withhold all information that tends to contradict what they would like the social worker to think about the child. The worker must be alert to notice whether the informant is withholding because of fear or protective pride, and she must divine any other attitude that may be back of it. The difficulty here is both in getting the proper information and in evaluating the reliability of the material that is given.

The social worker is in a good position to discover how the antagonistic or openly hostile person evaluates his or her problem and to learn why there is this feeling and toward whom it is directed. She provides an opportunity for the informant to tell what is on his mind without any attempt to smooth out the difficulties on a superficial basis. For instance, a father comes in with his child on instructions from the court and is at first antagonistic. He identifies the clinic with the court where he received the impression that the child would probably be taken from him. It is only after he has had an opportunity to reveal what is in his mind that he is able to understand that the purpose of the clinic is to consult with him and help him in the care of the child.

Then we find instances in which a mother does not really come for help with regard to the child's behavior problem, but is prompted by some other motive. She is felt to be decidedly half-hearted in revealing the problem. The social worker may finally discover that she really comes to the clinic to get a statement from an authoritative source, which she may take back to school, to the effect that her child is normal and should, therefore, be reinstated in his proper grade. Here the social worker must be constantly on the alert to size up the situation while the individual is talking and to try to understand from her manner and attitude the things she is actually revealing but not saying. She must also be aware that material is being withheld and if possible sense what that material is.

In other interviews an informant may be met who is quite willing, but apparently unable, to express herself spontaneously and after the first two or three sentences will volunteer no further information. With this type of informant questioning by the social worker may prove helpful.

Some informants encountered by the social worker are under considerable emotional stress. They may talk a great deal in a rather rambling fashion and may give much information with a strong emotional coloring. They consciously, or more often unconsciously, have something they want to prove. There is a great temptation on the part of the social worker to consider that all information given under such emotional strain is prejudiced. In order to get on with the history, she may have the desire to hold up the informant sharply or she may argue the point. Or possibly the worker may not be so much disturbed by the limited array of pertinent facts in the flood of information as she may be disturbed by the informant's skipping from detail to detail. This rambling might interfere with some social worker's desire to fit details into a paper scheme, and the social worker

may be tempted to bring the informant back to the point at issue. But unless the informant gets too far from the general question he should be allowed to ramble. Usually the individual who has a deep emotional bias and a strong urge to justify it will give the most vivid and colorful picture. The worker must be aware that a prejudice is very appealing to the person who holds it, that while he is seldom offended by an attack on his reason or judgment, he will enlist all of his abilities in behalf of his prejudice. Very careful use, therefore, must be made of material already given in recalling to the client's mind incidents or attitudes which are unpleasant to him, as the informant may unwittingly have betrayed himself. Unless the social worker has a special treatment purpose in mind, it is well not to recall information or to make interpretations.

The social worker will always find it wise not to commit herself definitely as to her attitudes since later these may be made use of by the informant somewhat in this manner. "Now you told me I was right in this and this." In other words, the social worker must be very judicious in her use of verbal assurances which are based on a superficial knowledge of the case. Such assurances may constitute an escape for both the social worker and the individual from facing the problem. It may cause an individual to feel that the things which have concerned him deeply are altogether too lightly considered by the social worker; he may be puzzled or shocked by her easy reassurances or he may feel that she is actually covering up her disturbance by a smooth minimizing of the material of his most intimate disclosures, material of great emotional significance for him. The success of the interview may at least in part be measured in terms of the worker's freedom from praise or blame reactions toward whatever the informant relates or shows.

Whatever the service may be that the child guidance clinic

has to offer and whatever the response of the individual seeking that service, the social worker should allow that individual to feel that the clinic is forcing nothing on him that he himself does not want. She helps him realize that his opinions are valuable and that the relation of the clinic to him is going to be a participating one, a mutual attempt to work out a clearer understanding, if not a solution of the problem.

History-taking with all it implies presents a very wide field and many of its other aspects might well be covered here if space permitted. This material was selected chiefly because it covers processes and tendencies common to all child guidance clinics at this time. It must be understood that we have presented that which is representative of the point of view and thinking of a child guidance clinic whose policies and procedures are constantly being modified and changed.

## Chapter VI

### THE MEDICAL STUDY

THERE is a tendency on the part of the less sophisticated laity, and even of a few members of the medical profession, to assume that the child who misbehaves must be a physically sick child. The experience of those who deal with behavior problems in children has shattered the basis for this belief. A child whose parents have spoiled him and continue to spoil him will continue to behave like a spoiled child despite any kind of medical treatment. On the other hand, with the popularization of mental hygiene and the resultant pseudo-scientific writing in this field, inadequately informed or careless writers have led a certain more sophisticated fraction of the laity and even of some professional groups to an attitude which is so exclusively directed to concern over psychic factors that it leads to the total neglect of the child's physical condition.

Both of these extreme attitudes are in error. Both are unfavorable to the successful management of child training, and it is desirable that those who deal with children should learn to balance the importance of both factors in relation to the particular child in question.

The physical examination of a child will, of itself, give an adequate understanding of misbehavior in only a relatively small fraction of cases. The recognition of these cases is none the less very important. Confining, for instance, the treatment of a child with a behavior disorder due to cerebral syphilis to attempts to modify the environment (because of neglect of physical study and consequent failure to diagnose



the disease) may be a fatal error. The physical examination is indispensable for recognizing those cases in which the disturbance of behavior is due to organic lesion of that portion of the central nervous system. In the remainder of the cases the physical examination will frequently aid in understanding the behavior and will commonly disclose defects such as dental caries, which are not usually significantly related to behavior, but which for the welfare of the child should none the less be corrected.

In a physical examination it is, of course, more difficult to obtain and retain the coöperation of a child than that of an adult. Many children seem to harbor a deep suspicion of physicians, and from their point of view one must admit the suspicion is not without justification. With young children a few moments spent in endeavoring to gain confidence, postponing until the last the more disturbing portions of the examination such as the inspection of the throat, and the expenditure of some effort in attempting to gain the coöperation of the child, besides the cultivation of a quick dexterity, will result in fewer difficulties and errors than would otherwise occur.

The effect of the physical examination on the attitude and coöperation of the child is frequently of greater importance in a child guidance clinic than in a medical clinic. It influences his attitude toward the clinic personnel as a whole and may destroy or promote coöperation in other examinations and in the entire therapeutic situation. In this therapeutic situation the child's coöperation is more vital than it usually is in medical treatment. In some instances in which a child on first contact is particularly apprehensive and his suspicions cannot be allayed even to the point of preventing active resistance to the physical examination, it may be advisable to postpone this examination to a later date.

There are grounds for protest, particularly in the child



guidance field, against the exploitation of a child's confidence by adults. Most of us can remember from our own childhood numerous instances in which the assurance "It won't hurt," was not given in good faith. When a slightly painful procedure such as venipuncture must be performed, it is in most cases scarcely less effective in securing coöperation to assure a child that it hurts but little and to appeal to his pride. This tactic has an advantage, for, although the child may doubt the doctor's judgment of someone else's pain, it is not a clear evidence of bad faith. We do not hold that there are no instances in which it is justifiable to betray a child's confidence for adequate reason. We do protest against the habitual and unthinking use of this device, which is all too common on the part of adults dealing with children, and of which physicians are by no means guiltless. Such practices are unfair, constitute bad training, and are self-defeating in the long run.

It lies beyond the province of this book to describe the procedure of the physical examination or to provide a treatise on physical diagnosis or a system of pediatrics, for many volumes are available on these subjects. There are, however, a few disorders of sufficient importance in the field of child guidance to require brief description.

In the usual medical treatise dealing with these conditions behavior is discussed very incidentally, if at all. Here, therefore, there is occasion for stressing certain organic disorders from the standpoint of the problems of behavior they create. The numerical incidence of these conditions in the clinic intake would not, of itself, justify even the small space we shall devote to them. However, some of the behavior problems associated with these disorders are peculiarly serious, chronic, and refractory to treatment, frequently necessitating institutional care for the protection of the community. Since the recognition of these conditions is a matter

of importance, some pages will be devoted to them. There will be extremely little space given to the more common and better known physical disorders which usually do not directly contribute in a major way to behavior maladjustments. The reader who has neither interest in nor any responsibility for the medical aspects of child guidance may desire to pass on to the next chapter.

### The Nervous System and the Special Senses

**Lethargic Encephalitis.** This is the most important of the physical disorders creating problems of behavior in children. It is also known as epidemic encephalitis, epidemic stupor, and European sleeping sickness.

Lethargic encephalitis is an infectious disease appearing in epidemic and in endemic form, usually beginning with an acute attack characterized by lethargy and cranial nerve palsies or by involuntary twitching or jerking of muscles, typically followed by a chronic, usually progressive stage marked by spasticity, tremor, loss of associated movements, and drooling.

Pathologically the disease is characterized by inflammatory changes in the brain. Any portion of the central nervous system may be involved, but the midbrain, pons, and basal ganglia, particularly, are apt to be damaged.

This disease was first recognized in 1916. It became widespread in epidemic form in Europe and America following the influenza pandemic. Its contagiousness is not high, only a few cases typically occurring in each locality.

The victims of this disease comprise about 2 per cent of the children examined at the Institute for Juvenile Research.\*

\*The medical history of children in whom a diagnosis of chronic lethargic encephalitis can be made, as obtained from the parents, will include a diagnosis of an acute attack of encephalitis in only a fraction of cases. In the remaining cases a history of influenza or of chorea is

Of the individuals affected, roughly a third die, a third recover, and a third develop chronic sequelæ of the acute attack, often of a progressive character.

This disease is important in the child guidance clinic because those cases which appear to be disturbances of volition are frequently among its victims. It should be stated at the outset that no disease is more polymorphous in its manifestations than lethargic encephalitis and the descriptions contained here portray simply the more typical forms of this disease.

Adults with lethargic encephalitis frequently show a surprising absence of urge to action. They may sit for hours with open mouth and stare into space. This is not due to frequent. Careful attention to the description of the disease will frequently reveal a history of characteristic or suggestive symptoms of lethargic encephalitis accompanying the illness so diagnosed or some other acute illness. Somnolence extending over several days may not even have occasioned the calling of a physician. If there is a history of acute illness with double vision or crossing of the eyes coupled with the somnolence, there is a strong probability that the illness was an acute attack of lethargic encephalitis. A history of "influenza" coupled with choreiform movements is extremely suggestive. Other diagnoses not infrequent for an illness which may appear in retrospect to have been an acute attack of lethargic encephalitis are infantile paralysis, meningitis, and catatonic dementia praecox. The differentiation of lethargic encephalitis from this disease last mentioned is sometimes difficult. Sometimes a chronic form of lethargic encephalitis develops in a case in which no history can be obtained of any illness suggestive of an acute attack of the disease. Other disturbances of sleep besides somnolence are frequent. A history of excessive wakefulness is not unusual. A characteristic symptom is restless activity during the night followed by sleep during the day in a regularly recurring fashion, i.e., reversal of the sleep cycle. The occurrence of sleep at unusual and unexpected moments in the daytime (narcolepsy)—on the physician's examining table, on the school stairway and so on—is not infrequent. In certain cases the cycle of body motility and that of sleep may be dissociated. In such cases the patient may toss restlessly in his sleep for the first portion of the night, sleep soundly and quietly for the last portion, awake and spend the morning sitting quietly and staring into space, becoming active during the waking stage only with the coming of the afternoon.

impairment of the intellectual functions, for these typically remain relatively unimpaired. A patient may be in an uncomfortable position and desire to move and yet have extreme difficulty in achieving a change of position, despite an intact intelligence and a clear appreciation of discomfort and despite an unimpaired or relatively unimpaired motor system. This behavior is perhaps best described as a disorder of the will. Such a patient may have extreme difficulty in voluntarily initiating an action which he may perform with promptness and facility in response to a sharp command. It may be necessary for an attendant to supply the impulse to action for the care of such simple body needs as bowel and bladder evacuation in a patient of good intelligence.

The reader is referred to von Economo\* for a peculiarly fascinating and illuminating discussion of the disorders of volition in lethargic encephalitis and their significance to certain fundamental problems of behavior.

The disorders of volition which are common in encephalitic children frequently take such positive forms as constant restless activity or sudden unprovoked outbursts of violence. Sometimes the eating habits are affected in peculiar ways. Some of these children take to eating flies, garbage, and other filthy or unusual materials (pica), some become gluttonous, some become exceedingly finicky.

Tics, frequent repetition of quick, simple, stereotyped movements are common in this disorder and sometimes assume peculiar forms, i. e., thumbing the nose or screaming. A history of short attacks of rapid breathing (polypnea) will sometimes be obtained or such attacks may be observed. Headaches are frequent.

Parkinsonism, a chronic, usually progressive syndrome named for its resemblance to Parkinson's disease (paralysis agitans) may develop immediately after the acute attack of

\* See Bibliography.



lethargic encephalitis. More frequently it first shows itself several months or years after the acute attack. Its development is nearly always insidious.

Stiffness and deliberateness in movement become apparent. The patient is slowed down. His arms no longer swing freely as he walks. His posture becomes hunched. His head hangs forward. The skin of his face assumes a greasy appearance. His expression fades, leaving an immobile mask-like countenance with a wide unwinking stare. His mouth hangs open, drooling a streamer of viscid saliva.

His elbows are held slightly akimbo, the hands partly closed. A coarse tremor shakes his fingers and thumb, sometimes moving them over each other in opposite directions in the so-called pill-rolling fashion.\* He may be able to inhibit temporarily this tremor to perform a skilled act, as threading a needle, but it recurs in a more violent fashion when the effort is relaxed. In many cases the tremor often also affects the legs. Less commonly it is seen in the chin or the muscles of the face. The protruded tongue usually shows it.

The patient's gait is stiff and labored. His body inclines well forward and his feet hurriedly follow with short, quick, shuffling steps. His speech is monotonous, without modulation of the voice, each syllable laboriously and mechanically articulated, sometimes in a jerky or explosive fashion.

The pupillary responses are of particular importance. Most characteristic is the loss of the pupillary response to accommodation while that to light is retained. More frequent are sluggish, irregular, unequal or eccentric pupils, or pupils totally fixed to both light and accommodation. A typical Argyll-Robertson pupil may be observed.

Where the picture of Parkinsonism is well developed, cog-wheel resistance is present at the elbows and knees. The tendon reflexes are typically exaggerated and the special signs of pyramidal tract involvement such as the Babinski, Rossolimo, and Hoffman reflexes are typically absent. Paralysis of the facial nerve is common, usually unilateral.

\* While it occurs in Parkinsonism, the pill-rolling tremor is more characteristic of Parkinson's disease.

Such a picture is occasionally seen in a well-developed form among children with chronic lethargic encephalitis. It may be arrested at any stage or progress to complete helplessness. In general it tends to be slowly progressive if it is once fairly well developed. Some of the features are usually present in the children afflicted with encephalitic behavior disturbances and are apt to be more pronounced on one side of the body than on the other.

Were the disturbances restricted to changes in the physical state, there would be no particular need for their discussion here, but some of the most important and dramatic aspects of the disease in children are to be found in the field of behavior.

Commonly parents complain that following an illness the personality of the child underwent a change. He became irritable, quarrelsome, restless. He displayed changeable moods and quick swings from excitement to irritability or crying spells. He became disobedient and assumed a defiant attitude toward his parents, was restless in his sleep, and exhibited frequent explosions of temper, often disproportionate to the provoking incident or even without provocation. There was impulsive behavior of a more or less bizarre character. When crossed, he might break the furniture, throw dishes, or assault the individual who crossed him. He was unable to get along with other children and would disrupt the atmosphere of the class room. He would run away aimlessly, steal, beg, lie, steal rides, and enter houses. He would engage in sex misconduct with absolutely no regard for community attitudes.

Behavior of this general pattern has a considerable diagnostic value in the recognition of lethargic encephalitis.\* Its

\* Among 5,000 consecutive cases examined at the Institute for Juvenile Research there were twenty-eight cases in which the case records contained the notations *change of personality*, *emotional instability*, and one or more of the three entries *temper tantrums*, *temper display*, or *irritability*. Scrutiny of the case records of these twenty-eight children



most characteristic feature is impulsiveness. For example, a small boy examined at the Institute was given a trifling punishment by his mother for misconduct. She went upstairs with the baby, and he built a fire under the stairway which provided the one course of egress. Commonly these children will recognize their behavior as abnormal and will exhibit contrition and a repentant attitude after an explosive outburst. The contrition, however, is short-lived and seems without effect on their conduct, which remains unimproved.

The possible power of these abnormal impulsives is dramatized in a case report by Goodhart and Savitsky.\*

A sixteen-year-old girl with Parkinsonian symptoms, who apparently had the acute attack of her encephalitis at age eight, developed a typical encephalitic behavior picture. She often prevaricated and had frequent temper tantrums in which she would tear her clothing and strike her mother. When confronted with the results of her destructive conduct, she readily admitted her misdoings and said that "she could not help it." On a number of occasions she broke windows in the house during these explosive episodes. At times the outbursts were in reaction to no evident situation. Occasionally these tantrums would be followed by an hour of somnolence. She frequently became remorseful and would spontaneously reiterate, "Why do I do it? Why do I do it? I can't help it." She would readily strike her sisters when they interfered with her desires or angered her. Her school work was nevertheless good. Later this girl, in response to her compelling urges, extracted all but nine of her teeth, and enucleated

revealed that in twelve there was definite reason aside from behavior to believe that the child was afflicted by epidemic encephalitis. In addition to these twelve cases there were among the twenty-eight, eight other children whose case records indicated that they were perhaps also encephalitic. (Of course these cases constitute only a fraction of the encephalitic children among the 5,000 cases.)—R. L. Jenkins, M.D., and Luton Ackerson, Ph.D., "The Behavior of Encephalitic Children," *American Journal of Orthopsychiatry*, IV, 1934, pp. 499-503.

\* S. P. Goodhart and Nathan Savitsky, "Self-Mutilation in Chronic Encephalitis," *American Journal of Medical Sciences*, 185:674-684 (1933).

both of her eyes with her fingers. In explanation she later said, "I was like hypnotized at the time. Something made me do it." She was, despite this declaration, apparently mentally clear, able to talk rationally and answer questions intelligently immediately after this self-mutilation.

This case is unique in the literature and it is not to be inferred that encephalitic children commonly show self-mutilatory tendencies of comparable degree. Self-mutilation is, in fact, not at all common in this condition. This case is cited merely as a demonstration of the compelling power which abnormal impulses may have in children afflicted with chronic lethargic encephalitis.

Present knowledge includes no adequate therapeutic weapon for the treatment of the behavior disorders of encephalitic children. These children nearly always react badly to the common methods of discipline. Some of them require institutional placement for the protection of the community. Since these disorders are typical of individuals who had their encephalitic attack in childhood and are uncommon among those whose acute attack came in adult life,\* it would appear that the disease tends less to disrupt a socialized behavior pattern than to interfere with its formation. If, then, it were possible to hold in check the emotional outbursts and impulsive behavior of children with encephalitic behavior disorders through a period of childhood training, there might result adults capable of adjusting to the community.

The most promising type of treatment so far developed is that employed in the special institutional school developed at the Pennsylvania Hospital by Dr. Carl D. Bond. In a quiet, tolerant, "padded" institutional environment with a

\* Adults who are the victims of lethargic encephalitis are much more commonly afflicted with Parkinsonism than are children and are much less likely to manifest a behavior disorder. However, these two sequelæ may affect the same individual.

specially trained staff, most of these children greatly improve in their behavior. This improvement or some part of it may be retained on leaving the institution for favorable surroundings in the community. Consideration of the management of the encephalitic child in the community is undertaken in Chapter XIV, page 310. For a consideration of the etiology, pathology, and differential diagnosis of this disease and others here described the reader is referred elsewhere.

**Antenatal, Natal, and Infantile Encephalopathies.** The title of this section covers a group of conditions among which the two following descriptions are typical and for which there is no satisfactory inclusive term. Commonly used terms are: birth palsy; infantile cerebral paralysis; cerebral spastic paralysis; Little's disease; Strumpell's encephalitis; infantile hemiplegia; infantile diplegia; infantile paraplegia. These terms are satisfactorily descriptive of certain cases but no one of them is inclusive enough to cover all the cases.

A not infrequent picture at any children's clinic is the following:

A child stands with one heel lifted and the knee is slightly bent. The corresponding arm is held close to the body, flexed at the elbow and the wrist, with the fingers curled firmly to the palm which is turned down. The skin of the palm is soft, thin, moist, and semi-transparent. In walking one leg functions normally; the other, with the lifted heel, lacks normal freedom of movement. The muscles of the affected extremities are tense, but appear slightly smaller than the corresponding muscles of the normal side. The lack of movement of the affected leg is compensated for by increased movements of the trunk, pelvis, and the normal leg. The child swings his body and leg stiffly and jerkily as though they were all of one piece. He drags his affected leg forward, sometimes with a circling movement, in a shuffling or sliding fashion, swinging the trunk and pelvis with the leg. He is unable to lower the heel of the affected leg to the floor while standing with his foot directly beneath him. There is a

weakness and a partial paralysis of the affected side of the body. The child is unable completely to extend his elbow, his wrist, or completely to open his hand. Each movement of the paretic side of the body is stiff, awkward, and jerky.

Such a child is so effectively portrayed in Rivera's painting, "The Beggar Boy" (Louvre), that a diagnosis of infantile hemiplegia can be made at a glance.

Another picture commonly observed is that of the child who has little or no apparent paralysis but who continually makes irregular, more or less grotesque, movements. In some cases these are constant, slow, and wormlike (athetoid); in others, quick, irregular, and jerky (choreiform); or they may be intermediate between these forms. The muscles of the face are frequently involved. Involvement of the muscles of articulation causes indistinct, jerky, sometimes more or less explosive speech.

The form and severity of the symptom picture depend upon the location and extent of the brain pathology rather than upon the causative agent. Residual symptom pictures, clinically indistinguishable, may be produced by violent damage to the brain during or after birth, by inflammation of the brain before or after birth, by malformation of the brain, or by hemorrhage caused by disturbances of physiology such as abnormal fragility or permeability of the intracranial blood vessels.

It is therefore impossible successfully to divide all these cases among ætiological pigeonholes such as birth palsy\* and Strumpell's encephalitis.

A symptomatic classification is no more satisfactory, since the symptoms overlap, and yet there are none which are constant through the total group.

\* The term "birth palsy" is an unfortunate one since it has been used for the spastic paralysis occasioned by brain trauma at birth and also for the peripheral, flaccid palsy of the arm (Erb's paralysis) occasioned by traction on the brachial plexus during delivery.



Where the damage is due to injury at birth,\* the history is usually one of a prolonged, difficult labor, perhaps terminated by forceps, or of the delivery of a premature child. Children prematurely born frequently suffer brain injuries in deliveries which cannot be considered difficult. In some cases brain injury occurs in the course of a delivery which would otherwise be classified as entirely normal. As might be expected, since first labor is typically the most difficult, children injured at birth are preponderantly first-born children. Frequently, during the process of birth, veins are torn in the meninges or tentorium of the infant; sometimes blood vessels within the substance of the brain itself are ruptured. There is intracranial hemorrhage, which increases the intracranial pressure. This increased pressure usually manifests itself clinically. The nursing reflex may be lost. The body may be rigid, the head perhaps retracted. If the hemorrhage is extensive, the anterior fontanelle will be tense and bulging, and usually there is muscle twitching. Generalized convulsions frequently occur.

There may be irritability with a peculiar whining cry, or apathy and somnolence with intermittent cyanosis. In the majority of instances in which such symptoms occur and death does not supervene, recovery is complete so far as the present methods of clinical investigation reveal. In certain cases, however, there are permanent consequences.

If the child has had an illness which caused inflammatory brain damage, it is usually possible to get a history of acute cerebral symptoms during that illness—convulsions, stupor, retracted head.

The more serious and striking residuals of these encephalopathies are paralysis, involuntary movements, convulsions, and mental deficiency.

\* The physical trauma of birth should not be confused with the presumed psychic trauma of birth of which Otto Rank writes.

The paralysis is the result of destruction of motor nerve cells located in the motor area of the cerebral cortex (upper motor neuron lesion) or of their processes in the descending cortico-spinal tract which carries their fibers to the anterior horn cells in the spinal cord. The paralysis may be of any degree from a scarcely noticeable paresis to a complete loss of function of the affected part. In contrast with acute anterior poliomyelitis or infantile paralysis in which the damage is to the anterior horn cells in the spinal cord (lower motor neuron lesion) and the paralyzed muscles are relaxed, flaccid, and toneless, this paralysis is usually spastic, i.e., the affected muscles are tense, hypertonic, rendering the extremities stiff. There is failure of normal relaxation of opposing muscles during movement. Consequently, every movement must be made against muscular opposition. This results in ineffective, wasteful, and wearying use of muscular energy, and stiff, awkward movements. The muscles of articulation may be involved, rendering the speech indistinct and labored.

If the paralysis is severe, since the tonic pull of the muscles of flexion is at certain joints stronger than that of the muscles of extension, the joints are kept permanently flexed. This is followed by shortening of the muscles of flexion, which shortening may make impossible the full extension of the joint, i.e., may cause the development of a contracture. This is responsible for the cross-legged "scissors" gait of some of these children and for the lifted heel (*pes equinus*) which is rather common.

The distribution of the paralysis is in keeping with the usual behavior of cerebral palsies. In about two thirds of the cases it is a hemiplegia, as in the first case described, i.e., it involves one lateral half of the body on the side opposite the affected motor area. Less commonly it is a double hemiplegia (*diplegia*) or it involves both sides of the body below some transverse level (*paraplegia*). Rarely only one limb is involved. Often the residuum of a hemiplegia will be so slight as to be apparent in only one extremity, yet examination of the reflexes will reveal characteristic changes in the responses of the homolateral extremity. Often no paresis at all may be apparent and yet pathognomic reflexes may be elicited.



The extremities of children afflicted with marked athetosis or choreiform movements are in constant involuntary irregular motion during the waking state. In some cases the movements continue even during sleep. These involuntary movements may be superimposed on a fairly good basic coordination. Involuntary movements necessarily result in some degree of incoördination. Incoördination may exist without involuntary movements, for instance by reason of a cerebellar lesion.

Convulsions may occur and may extend throughout the life of the patient. They are an unfavorable sign. Clinically they may be indistinguishable from so-called idiopathic epilepsy. Both grand mal and petit mal may occur. It seems probable that some of the patients diagnosed as having idiopathic or essential epilepsy have convulsive seizures by reason of brain damage acquired in infancy.

Mental deficiency of any degree may occur. In general, brain damage in infancy, unless mild, leaves its mark on the mental abilities. On the other hand, some children severely handicapped physically from brain injury prove to have superior or even brilliant minds. Mental deficiency is more common and is likely to be more severe with diplegias and paraplegias than with hemiplegias. It is much more difficult to estimate fairly the intelligence level of these handicapped children than is the case with normal children, particularly when the physical handicap is severe.

The behavior of these children is by no means unaffected by their brain pathology. Aside from the modifications occasioned by physical handicaps or mental retardation, many of the children show a constant restless activity and an inability to relax. The normal inhibition of reactivity is interfered with. They tend to over-react to any stimuli, both physically and psychically. They are, therefore, easily distracted and over-excitible. The spasticity and involuntary movements are in-

variably worse under excitement or during effort. The attention span is short. They fatigue easily.

Probably most cases of mild brain damage, such as may be occasioned by an attack of measles, are missed by the physician in ordinary later contacts with the child. Where the damage is serious his attention is caught, but in the more numerous cases where the damage is slight he may pass over the case without recognizing its presence. Careful study will reveal evidence of mild brain damage in many children ordinarily classified as simply retarded, dull, "nervous," or fidgety. Study of a retarded or a "nervous" child may often reveal such indications as a history of difficult forceps delivery with marking of the head and neonatal convulsions, coupled with unilateral positive plantar response, with an increased homolateral patellar jerk and ankle clonus. In the mild cases certainty of diagnosis is often impossible.

The most important factors in determining the educability and ultimate adjustment of children handicapped by brain injury are the intelligence level and the presence or absence of convulsions. Occasionally recourse to brain surgery is justified, particularly in the presence of convulsive seizures, for the relief of the pressure and irritation occasioned by a scar or cyst. If the intelligence is good and there are no convulsions, the success attained in overcoming the physical handicap is often surprising. Massage and a muscle training program, supplemented where indicated by orthopedic surgery, serve to reduce the physical handicap. The first essential for the acquisition of motor skill in these conditions is relaxation. Exercises are therefore often begun in a warm bath. Relaxation is no less important for general training than for muscle training. These children tend to be excited more easily than do normal children and to react badly to excitement. Quiet handling and protection from over-stimulation are usually important in their training. Training needs to be

given in smaller doses than are usual with normal children and rest periods should be interspersed generously.

**Epilepsy.** The most characteristic manifestations of epilepsy are the major seizures or grand mal. The child is most apt to call them simply "the big ones."

The child may have an aura, or warning of an impending attack, which may send him scurrying to the nearest parent. This aura may be, for example, vague visceral sensations, flashes of light, ringing in the ears, tingling in some part of the body, the sensation of a peculiar odor, dizziness, or a jerking of certain muscles. It may be in any one of the sensory fields and may take any one of an infinite variety of forms. Usually the aura, if it is present, is constant for the individual.

The attack begins with loss of consciousness, and may be marked by a sudden cry, often of a sighing or whining character. This is not a conscious cry, but is produced by the tonic spasm of the chest muscles forcing air violently through the closing glottis. The child falls stiffly, frequently striking his head. The extremities are rigid, the jaws clenched, the body muscles taut, the head drawn to one side, the eyes staring and glassy, with widely dilated fixed pupils. The violent contraction of the abdominal muscles at this time or during the clonic stage may forcibly expel urine or even feces. The tonic spasm of the muscles of the chest increases the intrathoracic pressure, damming back the venous return. The face becomes livid, veins engorged and prominent, the expression distorted by muscular spasm. As the attack continues, cyanosis develops, and the lividity deepens to a dusky purplish blue.

After a period of seconds the tonic seizure passes into a clonic seizure. The extremities and head jerk violently and rapidly back and forth, or beat against the floor, the jaws snap open and shut, perhaps lacerating the tongue. The eyes jerk and roll. As the clonic seizure continues the glottis opens and breathing is reestablished. It is slow, deep, violent at first, bubbling frothy and perhaps bloody saliva through the lips. If the child is lying on his back the tongue may fall back into the throat and partially interfere with the breathing

which, in this case, develops a rough gasping obstructed sound.

As the breathing becomes more adequate, the cyanosis fades. The clonic seizures become less violent, then intermittent, and as the muscles relax there may be relaxation of sphincter control and passage of urine or feces. The attack passes off in a deep sleep from which the waking is gradual. After an attack the child is pale and exhausted, and usually has a headache for several hours. When this has passed he is apt to feel better than on the two or three days preceding the attack.

If the child is artificially roused from the post-convulsive sleep, he is apt to be confused, irritable, and afflicted with a violent headache. Aimless wandering and acts of violence sometimes occur in such a dazed condition.

The foregoing description is to be taken as merely typical. The attacks have an endless variety of individual differences, but tend to be constant for the same individual. There are many incomplete attacks. Sometimes only certain muscle groups are involved, usually without loss of consciousness (Jacksonian epilepsy). Verging into these are the less spectacular, but scarcely less characteristic, minor attacks or petit mal. These are often merely a transient loss of consciousness. The child pauses for a moment with a fixed unwinking stare, perhaps dropping a toy from his hand. There may be a slight muscular contraction, as the drawing up of an arm. A moment later he goes on with his play as though nothing had happened. These minor attacks may be very frequent, occurring forty or more times a day. They may be preceded by an aura and are sometimes followed by confusion.

"Epileptic equivalents" are transient disordered mental states which appear to be a substitute for epileptic attacks. In these states the child may behave in practically any fashion and have no recollection of his actions afterward.

Epilepsy is not properly speaking a disease. It is a symp-



tom complex. Symptoms similar to those here described may occur in a wide variety of organic diseases of the brain—birth injury, encephalitis, skull fracture, concussion, brain tumor, cerebral hemorrhage, cerebral thrombosis, neurosyphilis, chronic absinthe poisoning, hydrocephalus, meningeal hemangioma, tuberous sclerosis. When epileptiform seizures occur in the presence of organic brain disease, e.g., birth injury, they are classified as symptomatic. Jacksonian attacks are particularly likely to be symptomatic. With the great majority of epileptics the attacks cannot be ascribed to any recognizable organic disease. These cases are classified as essential or idiopathic epilepsy. Epilepsy is important in behavior first by reason of the direct epileptic behavior manifestations. These psychic reactions may precede, follow, or replace the typical attack. Frequently they are characterized by automatism or confusion. The sufferer may undress without regard to his location. He may wander aimlessly and come to himself hours later without any knowledge of where he is or how he got there. He may mechanically destroy objects within his reach. Occasionally there develops a frenzied maniacal excitement, the epileptic furor. Hallucinatory states of a transient nature are not rare, at least with adolescents. They are most frequently of a religious character. The child may see and hear the angels singing on the golden stairway. The confused or “twilight” condition of epilepsy is a potentially dangerous one. It is most common in patients roused artificially from post-convulsive sleep. On occasions children have been known to make attacks of violent and brutal ferocity during an epileptic state.

The epileptic attack may be preceded or, more rarely, followed by a period of irritability, depression, or other psychic change not marked by interruption of consciousness.

The epileptic constitution has been variously described and

the descriptions are not in perfect agreement. There is probably agreement on the following:

Typically the child is self-centered, irritable, and complaining, inclined to be mistrustful. If he is beyond early childhood he is likely to have a violent temper, but otherwise his emotional spectrum may be faint and indistinct. By adolescence he has typically developed a shallow and undigested religiosity. In his religious ideology he may find sanction for cruel and antisocial fantasies.

If the disorder is severe and the attacks are frequent, emotional and intellectual deterioration frequently supervene and may be very marked.

Epilepsy is very frequent among the feeble-minded. In symptomatic epilepsy, cure may be effected if the responsible brain lesion can be successfully treated. In both symptomatic and idiopathic epilepsy the attacks may be reduced in frequency or completely held in check by medical treatment. Phenobarbital, the bromides and ketogenic diet, and restriction of fluids are the measures most generally useful. These measures are likely to be less effective in symptomatic than in idiopathic cases.

If the epileptic seizures can be held in check, the psychic equivalents or accompaniments are usually likewise controlled, although the essential character of the epileptic constitution remains unchanged.

The success obtained in the treatment of epilepsy is frequently surprisingly good and the success which intelligent and interested parents have in avoiding unhealthy mental attitudes in epileptic children even where the seizures cannot be entirely controlled is often striking.

**Syphilis.** About 2 per cent of the children examined at the Institute for Juvenile Research are infected with syphilis. In about 43 per cent of these cases there is evidence of the



disease having invaded the central nervous system. This percentage is, of course, much higher than that of syphilitic children in general, because of the type of selection which determines the referral of children to a child guidance clinic. In pre-adolescent children the disease is usually congenital, that is, present from birth, the infection having been acquired from the parent before birth.

The invasion of the central nervous system by this disease may result in a remarkable variety of symptoms. In general the symptoms are those of a diffuse involvement of mild intensity, and the course is highly variable, with remissions and exacerbations.

The period of invasion of the central nervous system is apt to be marked by headache and vomiting. Slight fever may be present. Cranial nerve palsies are very common. These may be followed by the development of a paralysis of extremities, such as a paraplegia, usually spastic. The paralysis may be associated with disturbances of sensation—anaesthesia or hyperaesthesia.

A history may often be obtained of miscarriages or stillbirths preceding the birth of the syphilitic child and this has suggestive value. Small blisters on the soles and palms at birth (bullae), or snuffles in infancy may be described.

Frequent in congenital lues are small incisors, smaller at the free margin than at the base, with a central notch (Hutchinson's teeth), a nose sunk at the base (saddle-nose), and thin, jagged, linear scars about the mouth (rhagades). These signs are no more than suggestive and are usually absent.

The enlargement of the epitrochlear glands is a sign which, though useful in infancy, is almost valueless in childhood because of its frequency in normal children.

The pupillary reflexes are particularly significant in the recognition of syphilis of the central nervous system. Almost

pathognomic is the so-called Argyll-Robertson pupil. Such a pupil fails to respond to light but reacts to accommodation. The pupils may be unequal, irregular, eccentric, or sluggish in their reaction to light. Symptoms of damage to the corticospinal tract, i.e., spasticity, hyperactive tendon reflexes, positive plantar signs, Hoffman's sign, Rossolimo's sign are common.

Most commonly the major changes in central nervous system lues are located in blood vessels. Syphilitic meningitis is not common and rarely do gummas of the meninges occur. Of the two classical forms of parenchymal involvement, paresis and tabes dorsalis, the former deserves mention as it occurs in children.

Occasionally paresis is seen in a child, usually about, or slightly before puberty. The pupils are fixed, irregular, unequal. There is a fine tremor of the hands and tongue. The speech is slurred.\* The memory gradually becomes undependable. School work slumps. Hallucinations may be evidenced. Rarely is there the spectacular grandiose development seen so often in adults. Deterioration is the outstanding change. The writing becomes illegible. As the mentality fails, speech becomes incoherent.

Evidence of a disordered mentality is not rare in other forms of neurosyphilis than juvenile paresis and does not necessarily indicate the relatively unfavorable prognosis of this form.

Juvenile paresis, like the adult form, is treated by periods of induced fever though apparently with less favorable results than are obtained with adults. Other forms of cerebrospinal lues frequently respond very well to treatment with arsenic, mercury, bismuth, and potassium iodide.

\* It should be remembered that the test phrases used for adults are in general too difficult for children. "Christmas tree," "mistletoe," "dash past," are sufficiently difficult. Normal children will usually stumble on "Methodist Episcopal."

**Other Diseases or Malformations of the Nervous System.** The reader is referred elsewhere for consideration of meningitis, hydrocephalus, chorea, tuberculosis of the central nervous system, intracranial tumors, abscesses of the brain, sinus thrombosis, the various congenital malformations of the central nervous system, the wide variety of degenerative diseases such as amaurotic family idiocy, multiple sclerosis, and other types of the nervous system pathology.

The autonomic nervous system is of considerable importance in the determination of behavior, but the means of diagnosis and treatment are as yet not well established.

**The Special Senses.** The examination of the special senses is of particular importance in a child guidance clinic. Not rarely failure of school progress may be traced to an unrecognized defect of vision or hearing. Because of its importance in the recognition and detection of neurological disease, the routine use of the ophthalmoscope should not be neglected.

**General Deficiencies of Development: Mongolism.** A condition which deserves mention by reason of the frequency with which it appears in child guidance clinics is mongolism or Mongolian idiocy.\*

This is a condition of general developmental defect, invariably including defective development of the mental faculties.

The diagnosis of mongolism is made by physical examination and the inevitably defective mental and physical development of the child can be predicted from birth, although the recognition of mental deficiency by psychometric tests is of course not possible until later.

\*This is a misnomer; most of these children are not idiots, but imbeciles; neither are they Mongolian.

These children are short and squat with relatively short legs. The muscles and ligaments are hypotonic; the heel can usually be placed on the head without any difficulty. The face is broad and flat, the eyes small, slightly almond shaped with an elevation of the outer corner (which gives them a slanting position). Frequently a fold of the upper lid extends over the inner corner of the eye (epicanthus) as in the Mongolian races. These children have enlarged tonsils and adenoids, and most of them exhibit the typical adenoid facies. There is often a marginal inflammation of the eyelids, fissuring of the lips or a running nose. The tongue is often marked by deep transverse fissures; the external ears usually small and rather simplified in form. Abnormalities in the development of the heart are very frequent. The genitalia are under developed. There is pot belly and often umbilical hernia. The hands are short and spatulate, with short fingers. The little finger is likely to be particularly small, reaching perhaps only the first interphalangeal joint of the ring finger and the palm pattern is frequently simplified, most typically the usual pattern being replaced by a single transverse crease (simian plan pattern). The big toe is likely to be set widely from the other toes and often there is a crease down the plantar surface of the foot, from the first interdigital space.

The head is small and round, being flattened at the occiput. The posture is slightly hunched with the head projecting slightly forward. This, with the squat build and flat occiput, is so characteristic that these children can usually be picked out even on being seen from behind. The voice is harsh.

Evidence from the relationship of mongolism to twinning \* indicates that its cause is located at least as far back as the zygote. In very few cases does this defect appear more than once in the same family.

Evidence from the relation of mongolism to maternal age (its incidence increases as maternal age advances) and its association with a lowered fecundity, suggests that it may

\* When mongolism occurs in conjunction with monozygotic twinning, both twins are affected by the condition. When it occurs in conjunction with dizygotic twinning, only one twin is affected.



be due to degenerative changes in the ovum from which the mongol develops. These children have an infant and childhood mortality about ten times that of normal children. Relatively few reach adulthood.

The important differential diagnosis of mongolism is from cretinism, which in this country is much less common. A table of differential points can be found in practically any text dealing with this subject. To the experienced eye the evidence is nearly always clear.

**The Endocrines.** The understanding of human behavior will be materially advanced by information gained from a study of the endocrines. The proper evaluation of their rôle remains in large part a problem for the future. Unfortunately quasi-scientific and pseudo-scientific writers have misled the laity with a reckless presentation of hypothesis and presumption as though they were scientifically established facts. Despite popular notions to the contrary, there is a dearth of accurate knowledge of the relation of the endocrines to behavior at the present time.

Mention has already been made of cretinism, a condition of general maldevelopment associated with a congenital absence or deficiency of the thyroid gland. Every physician is acquainted with the "nervousness," the emotional over-reactivity, tenseness, worrisomeness, inability to relax, characteristic of patients suffering from exophthalmic goiter and toxic adenoma of the thyroid. These are uncommon before adolescence.

The parathyroid bodies (and the blood calcium level) deserve further study with reference to their rôle in behavior than they have received.

The rôle of the gonads in determining behavior scarcely needs mention. Recent endocrinological advance has demonstrated the interdependence of the gonads and the hypophysis. It is furthermore probable that this latter body, about



which physiological knowledge has been expanding so rapidly of late, has some direct importance in behavior. The rôle of the adrenals in response of the organism to fright or other emotional stimulation is now appreciated. Further study of these bodies will probably be fruitful in the understanding of behavior.

The direct rôle of the pancreas in behavior has become apparent with a recognition of hyper-insulism from over-function of the insular tissue. Paroxysms of hypoglycemia may produce convulsions or a confused state of the individual with erratic behavior often reminiscent of alcohol intoxication.

**Other Medical Disorders.** Many medical conditions are significant for their indirect influence on behavior. An infestation with the itch may, for example, so increase the child's irritability as to make him likely to develop a behavior disturbance which otherwise would not have arisen. Chronically infected tonsils or other chronic infection may operate in the same way to contribute to the behavior disturbances of the maladjusted child. It is much more difficult for the adult or child harassed by poor health to meet trying external conditions in a wholesome and effective manner.

Furthermore, there is often a psychic importance to conditions which are medically insignificant. The occurrence of common pimples and blackheads (*acne vulgaris*) in an adolescent is a condition of no medical importance so far as the general health of the child goes, and yet it may play an overshadowing rôle in his psychic life. Similarly harelip, undescended testicles, stunted stature, or frail physique may be the basis of a sense of inferiority of profound importance in determining an individual's maladjustment. Psychiatric considerations may at times strongly indicate medical treatment which would not have been recommended from a purely physical viewpoint.

Abnormalities which are not obvious to the casual observer may be none the less important psychiatrically. A child who has had the misfortune to lose a leg will meet a certain willingness on the part of his playmates to make allowances for his physical handicap, but the boy who is handicapped for active play by a heart lesion is apt to be disdained by the other boys as having no wind or no "guts." It is important, therefore, that the medical study in a child guidance clinic should be carried out with a consideration of the psychological results as well as of the strictly medical aspects of the child's physical condition.

## Chapter VII

### THE PSYCHOLOGICAL EXAMINATION

**T**HE clinical psychologist is concerned with the evaluation of the child's innate abilities, educational achievements, and special aptitudes. This evaluation is made mainly with standardized intelligence tests, achievement tests, tests of special abilities, personality schedules, and interest blanks.

Many have the erroneous conception that psychologists in devising tests have based them upon mere armchair analysis and classification of human abilities. As a matter of fact, it was the recognition and study of individual differences in the psychological laboratory which led to the development of reliable tests. Moreover, the tests as they now exist have been subjected to a long period of experimentation and refinement. Many different techniques of administering and scoring have been tried out, and statistical methods have aided in evaluating the results objectively. It is these tests, then, which the experienced clinical psychologist has at his disposal for the study of the individual.

With the results of the tests at his command the examiner can predict within certain limits the maximum school achievement to be expected of a particular child, the child's chance for success in some vocations, and, having discovered any special disabilities, he can also recommend special tutoring and treatment to overcome them. Furthermore, he can determine a child's abilities in special fields, such as music and art. Lastly, the psychologist can make recommendations regarding school grade placement when the child seems misplaced.

Psychological tests and measurements have been in the process of development for a period of over thirty years. The work was begun about 1900 by Alfred Binet in France. In this country Goddard, Terman, and Kuhlmann were among the pioneers in the field. During the World War the Army tests were given to over 1,700,000 men and this served as a stimulus to the testing movement. These tests were patterned after the previous group tests of Otis and were devised by a committee of prominent psychologists. Their value in enabling officials to classify properly and select men for special types of work emphasized to educators and psychologists the need for well-standardized tests applicable to various other groups. Later it was found possible by the use of group tests to classify school children according to their ability. Thus the group test was developed along with the individual examination.

It is not the *a priori* decision of a psychologist or group of psychologists which determines the subject-matter of the tests. Each examination goes through a careful process of standardization before it is acceptable for general practice. It is for this reason that the results obtained may be considered important. For example, whether or not an eight-year-old child should be able to point out the similarity of two objects such as wood and coal is decided only after the question has been asked of a large number of children at the different age levels. If this is found to be too simple a task for nine-year-old children and, on the other hand, too difficult a task for seven-year-old children, and if about 75 per cent of the eight-year-old children are able to pass it, it is located at this year level.

The process of standardization involves more than just the experimental work necessary for the placement of the tests at the various year levels. The subject-matter of the tests must be carefully considered, and the directions, scoring, and

norms by which the scores of individuals may be compared, must be made uniform. The purpose of the standardization is to make the examinations objective, that is, to eliminate the personal or subjective influence of the examiner upon the results. The subject-matter of the test is selected with reference to the mental process or ability to be measured. Obviously the content of a test measuring intelligence differs from that of a test measuring musical ability. The difficulty of the items which are included in the test, the timing, the length of the test, and the general organization have to be experimentally determined on a large number of children before the test is ready for use in a clinic. Directions are simplified and arranged so that they can be given to each child in the same way. The method of determining whether an individual test has been passed or failed must be as objective as possible to eliminate the need for a subjective decision on the part of the examiner. And lastly, as already mentioned, norms must be established so that a comparison of an individual's performance with that of a group can be made. All of this requires the giving of the examination to a large number of individuals at each age level in order to establish age norms within the range of the test. If the test is to be of general applicability, the groups of children taking the tests during the experimental period must be representative of the general population and not of one particular community or race.

In the process of constructing the tests there are two statistical concepts which must be considered, the validity and reliability of the test. The former, validity, indicates how truly the test measures that which it claims to measure. As a pint measure is valid when it can be shown by other instruments to measure exactly a pint, so is a test valid when comparison with outside criteria shows that it measures what it purports to measure. For example, on the Minnesota



Mechanical Ability Tests the criteria used were the quality and quantity of performance of a group of boys on specified types of shop work, each judged to involve mechanical ability.

Reliability is concerned with the question whether or not the test gives consistent results, that is, whether the same group of individuals when examined a second time on the test would receive relatively the same scores. For example, suppose a class is given a test and the children are ranked in order according to their performance; then, if the test, the reliability of which is high, is repeated at a later date, the order of the children remains practically the same. If, on the other hand, it is found that on the second giving of the test there is no correspondence between the rank order of the first scores and the second, then the reliability of the test is low.

The foregoing discussion of test construction has been given in some detail to emphasize the amount of thought, work, and experimentation which is required before a test can be used for practical purposes. Although tests are not perfect, and no one knows their imperfections better than the psychologist who uses them, they have been found to be more accurate than the opinion of any teacher, psychologist, or psychiatrist, no matter how well trained or how experienced he or she may be.

With the development of intelligence tests two further concepts have arisen which require explanation. The first of these, mental age (M.A.), represents the child's degree of intellectual maturity, that is, the eight-year-old child who earns a score equivalent to that of an average ten-year-old is said to have a mental age of ten. However, the M.A. by itself does not indicate his degree of brightness. It is only after a child's mental age is compared with his chronological age (C.A.) that his brightness is indicated. This, then, is the

second concept, the intelligence quotient or I.Q. In order to find a child's intelligence quotient his M.A. is divided by his C.A. If his mental age is equal to his chronological age as  $\frac{10 \text{ years (M.A.)}}{10 \text{ years (C.A.)}}$  the child's I.Q. is 1.00. The decimal point is commonly omitted and the ratio stated as 100. If, then, his mental age exceeds his chronological age his intelligence quotient will be above 100. When the reverse is true, the intelligence quotient will be below 100.

There have been many studies of the constancy of the I.Q. If a child of six years has an I.Q. of 100, will his I.Q. be 100 when he is twelve? Can we justify the use of a child's I.Q. as a basis in predicting his intellectual capacity for future achievement? The general conclusions drawn by Kuhlmann \* after extensive study, and substantiated by others, are as follows: (1) The I.Q.'s of children of average intelligence tend to remain constant. (2) Those of bright children or superior children tend to increase with age. (3) Those of dull children tend to decrease with increase of age. However, the tendency to increase or decrease is slight.

There are many factors which should be taken into account in evaluating the I.Q. First of all, are the imperfections in the test itself. It may be a more reliable and valid test at one age level than at another. An examination at one year level may be more discriminating than at another because of better selection of material. It is possible that there may be changes in the rate of mental growth which would affect the I.Q. The rate of mental growth may not be constant and may differ from child to child. Physical defects such as deafness or poor muscular coördination, diseases of the central nervous system such as encephalitis, states of confusion following epileptic seizures or due to psychotic

\* F. Kuhlmann "What the I.Q. Means Today," *The Nation's Schools*, February, 1933, Vol. XI, No. 2.

episodes, and special disabilities such as reading handicaps should be considered in the evaluation of the rating. Finally, environment as a factor cannot be disregarded. Differences in socio-economic backgrounds, the language spoken in the home, and educational opportunities also are factors to be considered in interpreting the I.Q. The tests are based upon an average American child.

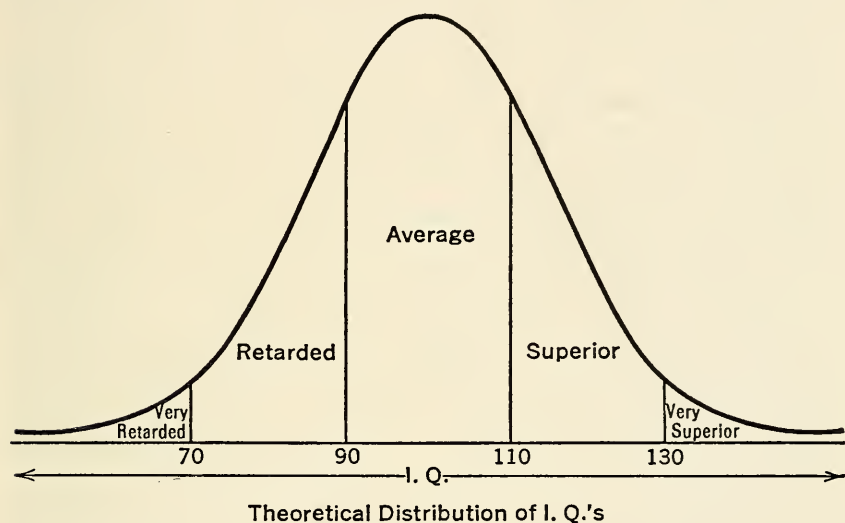
At what age does a child reach his mental maturity? Present results are confusing. Different psychologists have, from their investigations, located the average adult level somewhere between fourteen and sixteen years. Kuhlmann considers fifteen years to be the average upper limit of growth and Terman uses sixteen years. Differences in chronological age above the adult level are therefore not considered in the calculation of the I.Q. An adult of thirty-two years having a mental age of fifteen on the Kuhlmann-Binet will have an I.Q. of 100. Likewise a boy of fifteen having an M.A. of fifteen will also have an I.Q. of 100.

While it seems to be true that the average individual reaches an adult intellectual development at the age of fifteen or sixteen, some superior individuals may show increases in general intelligence up to eighteen or twenty years. Beyond this age the adult may enlarge his body of knowledge but not his ability to acquire it. This has been substantiated by experiments in examining high school and college graduates.

When a cross section of the general population is examined it has been found that the I.Q.'s are distributed approximately according to the normal probability curve. That is, the majority fall within the normal range of 90 to 110. As the extremes are reached, the curve falls off, the very retarded and the very bright being relatively few in number. The figure on page 87 is a theoretical distribution of I.Q.'s.

It will be observed that there are no distinct breaks in this curve. When classifications of I.Q.'s in general terms are

made, the question of the range of I.Q. which is to be included in a particular group is an arbitrary one. An individual with an I.Q. below 70 is classified as mentally defective, but to say that a child with an I.Q. of 69 is eligible for commitment to an institution for the mentally deficient and



one of 70 is not, is too fine a discrimination. A mentally defective child is no longer regarded as a person distinctly apart from the normal, but as differing only in degree of intelligence.

The following classification of I.Q.'s is the one suggested by Terman and the one most generally used in clinical practice.

I.Q.	CLASSIFICATION
Above 140	"Near" genius or genius
120-140	Very superior intelligence
110-120	Superior intelligence
90-110	Normal or average intelligence
80- 90	Dullness
70- 80	Borderline deficiency
Below 70	Definite feeble-mindedness

Although intelligence is not the only factor involved in school and vocational adjustment, it is undeniably a significant one. Many studies have been made which gave a basis for the prediction of vocational and educational achievement. For example, Proctor\* found that there are good grounds for predicting that 75 per cent of those who test below average mentally will fail in more than one half of their studies during the first year of high school, that 50 per cent will leave school to go to work during the first and second years, and that practically none will remain to graduate. As the chances of his graduating from high school are about 1 in 100 for a child with an I.Q. below 90, there is little purpose in having such a child take an abstract subject such as algebra or Latin. Similarly the minimum I.Q. for grammar school, high school, college, and many vocations has, within limits, been determined. However, it cannot be emphasized too strongly that the intelligence of the child is only one item in the possibility of his making a good adjustment. Interest, home background, social conditions, emotional stability, and many other factors are likewise important.

On the initial visit of the child to the clinic, the number of tests which he is given depends upon several factors, such as the child himself, the amount of available time, and the kinds of tests judged to be most significant in the particular case. No one child is given all the different types of tests. The time required for the giving of an individual test varies, depending upon the age of the child and the type of test. Fatigue, restlessness, and attention span are also factors which must be considered in the clinic's testing program. Frequently the psychological examination cannot be com-

\* Wm. M. Proctor, *The Use of Psychological Tests in the Educational and Vocational Guidance of High School Pupils* (Public School Publishing Company, Bloomington, Ill., 1931.)



pleted on the first day, and the child is asked to return at a later time.

Speaking generally, rapport with children of school age is easily established by skilled examiners. There is enough novelty in the test questions and materials to capture the child's interest, and the similarity to school situations usually puts the child at ease. Furthermore, most children enjoy the friendly attention which they receive. The psychological examination is of such a character that in cases in which the child's difficulty is not directly related to the school situation, it is unlikely that it will touch any of his emotional problems. When the problem is primarily one of school adjustment, a discussion of school is usually avoided until after the testing has been completed. This is especially the case in instances when the child has been placed in a special room very much against his wishes or when there exists some antagonism between the school and the family. However, in spite of existing school difficulties or unfavorable emotional attitudes toward the clinic examination, there are few instances in which school children fail to coöperate during the psychological examination.

The situation differs slightly with preschool children. They have been brought to a strange place without being able to understand why. Coöperation is sometimes difficult to establish, but with the aid of the parents and the attractiveness of the test materials their initial shyness is usually overcome, and they forget their surroundings. However, in all cases it is the function of the psychologist to recognize poor coöperation, hostility or shyness and to evaluate the ratings accordingly.

### Psychological Tests

The discussion which follows does not attempt to give the reader a thorough survey of the field of psychological

tests. The more common ones employed in clinical practice are used as illustrations. In general, tests applicable only to adults are omitted. The tests are grouped under four headings: tests of general intelligence; tests of educational achievement, including both those for general level and for diagnosis; tests for special abilities and vocational aptitudes; and schedules of personality traits.

**Tests of General Intelligence.** It is not our purpose at this time to discuss the meaning of the term "intelligence." \* Psychologists differ in regard to its exact definition. However, so far as intelligence tests are concerned it may suffice to state that there is general agreement between outside criteria and scores on the tests. For example, children without special handicaps who do consistently poor school work rate low on the tests.

Intelligence tests may be divided into two general types—verbal and non-verbal. Verbal tests assume an average acquaintance with the English language while the non-verbal tests assume little or no acquaintance with it. There are both individual and group tests for each of these types of intelligence test.

An individual test is one which can be given to only one child at a time, and a group test is one which may be given to a whole group at a single sitting.

The individual intelligence examination most widely used in clinical work is the Stanford Revision of the Binet-Simon Test (usually referred to as the Stanford-Binet) published

\* Binet defines intelligence as (1) the tendency to take and maintain a definite direction, (2) capacity to adapt to new situations to attain a desired end, (3) the power of autocriticism. Stern defines intelligence as a general capacity of an individual consciously to adjust his thinking to new requirements. W. Stern, *Psychological Methods of Testing Intelligence*, translated from the German by Guy Montrose Whipple, Educational Psychology Monographs, No. 13 (Warwick & York, Baltimore, 1914).

by Terman in 1916.\* The scale yields a mental age and from it the child's I.Q. may be determined. During the process of standardization there were 2,300 individuals who took the test. However, the final form is based upon the responses of 907 native-born subjects. The individual test items which appear at different age levels are those which give an average mental age at each level which coincides with the average chronological age for that given level. The probable error of an I.Q. obtained on the Stanford-Binet is  $\pm 5$ , that is, if a child's I.Q. is 100, the chances are fifty out of 100 that if the test were given at another time the change in his I.Q. would not be more than five points in either direction.

The Stanford-Binet Test is applicable to children from ages three through eighteen. Except for the higher levels there are six individual tests at each year level. The mechanics in administering the test involve the establishment of a basal age, that is, the age below the lowest year level at which the child fails an individual test item. After the establishment of the basal age, all tests are given in the succeeding age groups until there is a failure of all tests at one year level. The directions are specific and must be carefully followed before the results may be considered reliable. Some of the abilities tested are speed of response, vocabulary, memory, and reasoning ability.

In constructing the scale an attempt was made to minimize the influence of schooling by creating tests which offer relatively new situations to the child, such as repeating a series of digits backwards, copying designs from memory, pointing out the similarities of certain objects, giving sixty words in three minutes, and interpreting pictures.

Often for some special reason another intelligence test is

\*The Revised Stanford Binet Scales which have just been published will probably be substituted for the Stanford Revision.

preferred to the Stanford-Binet. There are other tests which are better adapted to particular age levels. Also, another test may be used as a check on the Stanford-Binet rating.

The Kuhlmann Revision of the Binet is one which may be used. This test appeared first in 1914 and was revised in 1922. It differs from the Stanford in the following respects. In the first place it has been extended at both ends of the age scale. At the lower level Kuhlmann's scale begins at three months. Secondly, many new tests are substituted for the least valuable ones of the Binet, and, in general, these tests depend less upon language. Thirdly, at each year level from three to twelve inclusive there are eight tests. Then there is a final group thirteen-fifteen which covers the adult levels. Fourthly, because of the manner of construction of the individual tests in the thirteen-fifteen group, the Kuhlmann-Binet lends itself to the examination of superior adults better than does the Stanford. Fifthly, in general, the scale has been made more objective by use of time and errors for scoring. Sixthly, it is more difficult to administer.

The Herring Revision was published in the same year as the Kuhlmann Revision. Again the individual tests are adaptations of the Binet. However, several new tests were added. In general, the Herring is more dependent upon language and complicated verbal patterns than are the other revisions. Therefore it should not be given when a language handicap exists. The total scale of tests is divided into five groups. The first group may be given alone, but because of its unreliability this is not recommended. However, to it may be added the second, the third, and so on, depending upon the available time. When more than one group is used the score on the first group determines which tests in the other four will be given. The Herring-Binet is not as difficult to administer as either the Stanford or the Kuhlmann.

The place of group tests in a clinic is limited. However,



there are occasions when they may be used as a convenient check on the individual test or when a child, due to some emotional difficulty, will react better on the group test. One explanation for the fact that some children do better on group tests is that a much less personal relationship is built up during a group test than during an individual test. Again group tests may be used in a clinic in the usual way when scholarship associations and like organizations request the examination of numbers of children.

In choosing a group test the age or grade for which it is designed must be considered. There are the primary tests (grades one to three), the tests for grades four to seven, tests for high-school levels, and tests for college students. The tests themselves contain material very similar to a school examination. The only material used is that which it is assumed the child has had an opportunity to learn. Of course this debars their use if the child's education has been irregular or if there exists a special defect such as a reading disability. But in general they are valid for children attending school. The tests involve following directions, assembling already learned facts, doing arithmetic problems, and so on. For example, the eight sub-tests which make up the Army Alpha battery are as follows: following directions, arithmetic problems, common sense, synonym-antonym, disarranged sentences, number series completion, analysis, information. Such tests assume that the children have had equal opportunity to learn the material required of them, and, in so far as this is so, they measure each child's potential ability.

As has been mentioned previously, the Army Alpha was one of the first group tests to be devised. Many of the group examinations which have subsequently been published have been based on its general plan.

The need for tests of general intelligence not dependent upon verbal expression gave rise to the construction of non-



language and performance tests. Incomplete pictures, mazes, drawing, form boards, and picture puzzles are types of material used. Thus memory, spatial relationships, forethought, and discrimination, which are some of the same abilities tested by language tests, are also measured by the performance and non-language tests.

Performance tests are a valuable means of examining young children and children with speech, foreign language, reading, or hearing handicaps. They are used in the clinic when it is obviously unfair to classify a child on the results of the language test.

Pintner and Paterson were the first to construct a performance scale. Their scale consists of fifteen different tests, each of which has norms ranging from preschool age to adult level. The child receives a mental rating on each test and the median of these is considered to represent his mental maturity. The directions are simple and easily understood.

The Kohs Block Design and Porteus Maze Scale are two single performance tests. The former consists of sixteen colored cubes and a set of designs. The cubes are alike and have sides of red, yellow, blue, and white, and a side which is red and white, and one which is blue and yellow. The child is shown the design and is instructed to make the same as quickly as possible out of the blocks. Timing and errors are noted for each design. A score is obtained and the total is converted into a mental age. The Maze test is based on the child's ability to find his way out through a complicated series of alleys, drawn on paper. There are thirteen mazes arranged in order of difficulty. They range from year three through adult.

These two tests with eight others taken from the Pintner-Paterson scale have been incorporated into the Grace Arthur Point Performance Scale. The child, depending upon his success, receives a score for each test. His total score may then

be converted into an M.A. equivalent. The age range for the scale is from five and one-half to fifteen and one-half years.

Similar to the Grace Arthur scale is the Cornell-Coxe Performance Ability Scale. There are seven tests, six of which make up the final score. They are (1) manikin-profile, (2) block designs, (3) picture arrangement, (4) digit symbol, (5) memory for design, (6) cube construction, (7) picture completion. The age range, four and one half to sixteen and one half, is slightly greater than that for the Arthur Scale.

Another intelligence test independent of language is the Goodenough "Drawing a Man" Test. The child is asked to draw a picture of a man. The child's score is obtained on the basis of his production of important details. Such items as shoulders, legs, features are considered; artistic merit is not taken into account. The age range for the test is from three to thirteen years. An M.A. may be obtained, and thus the child's I.Q. established.

The performance tests mentioned above are for the most part designed for children of school age, but there does exist a group of tests designed especially for preschool children. The testing material is colorful, interesting, and easily manipulated. Blocks, dolls, colored crayons, puzzles, and balls are some of the items used.

There are three preschool scales commonly used in the clinic: Gesell Schedules, Minnesota Preschool, and the Merrill-Palmer. The Gesell Schedules do not give a definite rating such as an M.A., but indicate the approximate development of the child. There are four fields of performance explored, i.e., motor, language, adaptive, and personal-social behavior. The range of the schedules is from one month to six years. The following items are typical of the ones which appear at the early levels: banging with the spoon, grasping

a ring held above the head, turning the head to the sound of a bell, holding two cubes, reacting to a mirror image, and saying simple words.

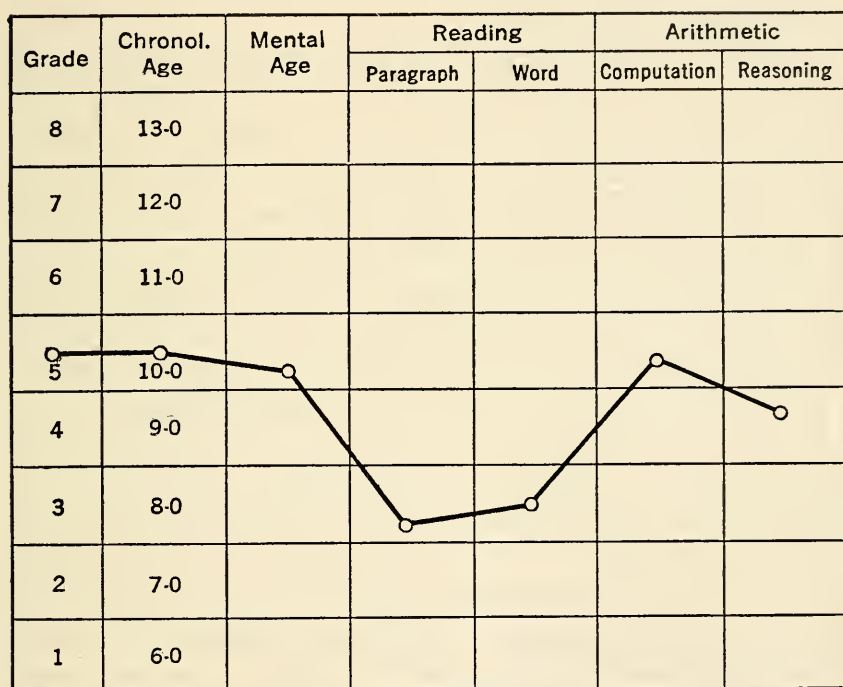
The Minnesota Preschool Scale is based on the results of tests given to 900 children. The scale itself is divided into verbal and non-verbal items. Thus, when there exists a language handicap of any sort, only the non-verbal items may be given. An I.Q. may be obtained from either a combination of the verbal and non-verbal scores or from each separately. Thus, a child's responses on verbal tests may be compared with his responses on the non-verbal ones and his relative development in the two fields compared. The material is very conveniently arranged and the norms extend from eighteen months to six years.

The Merrill-Palmer Scale may be given to children from one and one-half to six years of age. The individual tests are arranged in order of difficulty. The same type of material is used as has been earlier described. From the total point score an M.A. may be obtained. Norms are based upon the examination of 631 children.

**Educational Tests.** After administering the Stanford-Binet or any one of the general intelligence tests mentioned above, the child may be given school achievement tests. These are given in instances when there is a report of school failure, when the mental age grade placement is not in agreement with actual placement, when there seems to be a special interest or handicap in a certain subject, or when the child is referred because of truancy and incorrigibility. Achievement in practically all subjects may be tested. There are tests for single subjects such as reading, arithmetic, physics, and there are the batteries such as the Stanford Achievement which include almost the complete range of grade school subjects.

The tests are standardized on large groups of children.

The Revision of the Stanford Achievement was given to 5,000 pupils. The norms are based upon the average achievement of each grade. Therefore, in schools where the pupils are superior, achievement test norms may be too low; yet they are still valuable for making comparisons of the students within the same group. When a battery is given a comparison



of the child's achievement in different studies may be made. As can be seen by the profile, the child's relative achievement in arithmetic and reading may be quickly determined. The child whose profile of achievement is given above is two years retarded in reading in relation to his arithmetic computation. His actual placement is in the fifth grade, which indicates that his knowledge of the processes in arithmetic is up to normal. However, his reading, which is only third grade, is

two years retarded. This fact coupled with the report of poor school marks in reading would lead the examiner to suspect the possibility of a special reading handicap.

Following the achievement tests, diagnostic tests are given if it seems necessary. Although all tests are diagnostic in that they may bring to light discrepancies in the child's achievement, yet there are a small number which are designed to analyze specific handicaps.

It has been found through various investigations that 8 to 10 per cent of school children have special difficulty with reading, that is, their achievement in reading is markedly below their achievement in arithmetic and below the grade level ordinarily reached at their mental age. These children for some reason have not been able to benefit as much as would be expected by the regular classroom teaching. At the Institute for Juvenile Research this group of retarded readers composes about 20 to 25 per cent of all children examined.

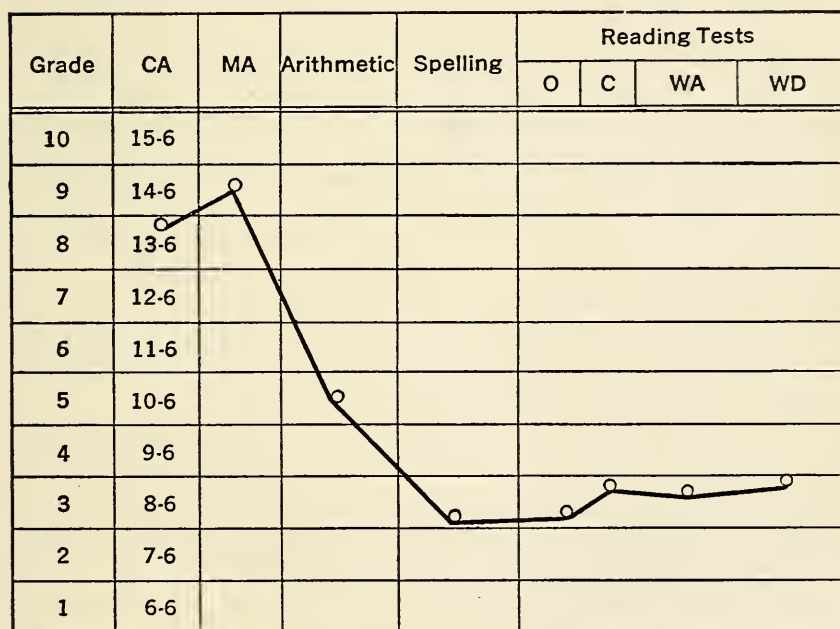
The Monroe Diagnostic Reading Examination consists of a battery of reading tests designed to measure oral paragraph reading, silent reading for comprehension, the reading of single words, and picking a given word from a list of confusion words which are very similar. All errors in reading made by the child are noted. These are analyzed into error types: vowels, consonants, reversals, addition of sounds, omission of sounds, and so forth. The child is then compared with a normal reader of his reading grade and his excessive errors are noted.

The Monroe examination contains several supplementary ones. The child's tendency to reverse single letters, such as "b" and "d," numbers such as "9" and "6," words such as "saw" and "was" and the child's ability to "mirror read" and write are compared with a normal reader's ability. Also his facility in blending sounds into words, which is important to his success in reading, can be compared with the normal



reader's ability. Lastly, tests of eye dominance and handedness are given. In order to obtain a basis for indicating the degree of retardation, spelling and arithmetic tests are also given. Thus, the child's achievement in reading may be compared with his achievement in arithmetic and spelling and with his expected school placement obtained from his M.A. and C.A. grade placement.

The following is a description of a typical case given by Dr. Monroe in her book *Children Who Cannot Read*.<sup>\*</sup> The accompanying chart indicates graphically the amount of reading retardation.



Charlotte was thirteen years of age when she was first examined. She had started to school at the usual age, but after a number of repetitions and general unhappy experi-

<sup>\*</sup> Monroe, Marion, *Children Who Cannot Read* (University of Chicago Press, Chicago, 1932), pp. 167-168.

ences at school was considered to be defective in intelligence. On the basis of this conclusion she was removed from public school and placed in a private school for defective children. She remained in this school for four years until the date of first examination. At that time she had refused to return to school, laid down the ultimatum that she did not intend to go to school again, and was prepared to defend her position with all the resistance of body and spirit. She was brought to the examination under pressure, and when the reading tests were presented she refused to coöperate, saying, "So this is what they brought me here for! Well, you might just as well mark me zero and go on." An explanation of reading disabilities was then given to her, showing her that they might occur in bright children and assuring her that she was not necessarily dumb just because she could not read. After giving the Stanford-Binet Intelligence Test, the examiner said, "You see, Charlotte, these tests make me know that you are a bright girl. A dumb one could not pass them. You are only thirteen years old, yet you succeeded with some of the tests for fourteen- and sixteen-year-old people." She seemed pleased for a moment or two, as if wishing to be convinced, and then retorted, "But these tests don't count. They don't make any difference. It's whether or not you can read that tells how bright you are."

Charlotte's reading showed an excessive number of errors in consonants, reversals, addition of sounds, omission of sounds, repetitions, and addition of words.

She was a fluent mirror reader and mirror writer. She was right handed but preferred the left eye in sighting. She had great difficulty in forming visual-auditory associations, and in blending sounds in word building. She was never secure in recognition of complex word patterns although she recognized the individual letters of words easily.

There are other diagnostic reading examinations besides Monroe's. Gates has diagnostic reading tests for both primary and advanced grades. The primary test includes word recognition, sentence reading, and reading of directions; and the upper test includes reading to appreciate general signifi-

cance, reading to predict the outcome of given events, reading to understand precise directions, and reading to note details. Each type of test has its grade norms.

In the field of arithmetic there are similar tests. The Buswell Diagnostic Arithmetic Chart or the Compass Diagnostic Arithmetic Test may be used to discover special difficulties. The fundamental processes, addition, subtraction, multiplication, and division, are studied. The child's method of attack is especially watched, as it may be at fault or his errors in combination may be the source of difficulty.

**Vocational Tests.** Often children are brought to the clinic for vocational guidance or for study of special aptitudes. Children thus referred are given vocational tests.

In this general field of vocational tests there are mechanical, clerical, and musical tests; tests of art (including both drawing and appreciation), typing, manual dexterity, and many others. Large industrial organizations have perfected many tests which can be used effectively to examine an applicant's ability in very specialized types of work. These are valuable for the particular company, but are not adapted to general use, the reason being that the tests apply to special skills or aptitudes for particular jobs and not to general ability which is a more important factor in directing the future training of children.

One of the most extensive studies of mechanical ability has been made at the University of Minnesota. The result was a battery of tests called the Minnesota Mechanical Ability Tests. Included in this are a paper form board test, an assembly test, an interest analysis blank, and a test of spatial relations. The child is thus examined in various fields which are necessary for success in mechanical work. Norms are given for ages and grades.

A forerunner of the Minnesota test was the Stenquist Mechanical test which includes both an assembly and an

aptitude test. The Minnesota Assembly is based in part on this test. The child is asked to put together common mechanical devices such as a bicycle bell, paper clip, and hinge. He is given a certain time and each device has a standardized score value.

Among the clerical tests there is the I.E.R. which is frequently used in the clinic. It requires the examinee to perform certain tasks which might be expected of him in office work. Following directions, copying numbers, simple arithmetic, comprehension, and English vocabulary are examples of the individual tests.

In the field of music there are the Seashore Musical Tests and the Kwalwasser-Dykema Test. The former consists of a series of Victrola records which are used to measure pitch discrimination, intensity, time, consonance, tonal memory, and rhythm. They are designed for grades five to eight, and for adults. Pitch, intensity, and memory are the most useful tests.

The Kwalwasser-Dykema Music Test consists of ten records. The following abilities are measured: (1) tonal memory, (2) quality discrimination, (3) intensity discrimination, (4) tonal movement, (5) time discrimination, (6) rhythm, (7) pitch, (8) melodic taste, (9) pitch imagery, (10) rhythm imagery.

There is a difference between these two tests in the matter of administration, the Kwalwasser being slightly easier to administer.

The Meier-Seashore Art Judgment Test is designed for high school and art school pupils. It consists of 125 pages of pictures. They are arranged in pairs, the two pictures of the pair being almost identical. The examinee is told how the pictures differ and is to make a choice, on the basis of this difference, as to which picture is the most aesthetic and pleasing. Although this test has been carefully worked out

and standardized, it obviously has its limitations. It does nothing in the way of testing creative ability which is an important factor in success as an artist.

A test which may be used successfully along with the Meier-Seashore test is that of Fundamental Abilities of Visual Art devised by Lewerenz. It measures actual performance and is divided into nine parts: (1) recognition of proportion of designs (judgments of designs and shapes), (2) originality of line drawing (actual drawing), (3) observation of light and shade, (4) knowledge of subject-matter relative to art work, (5) visual memory of proportion (the child has to draw from memory a picture of a vase form), (6) analysis of proportion in cylindrical perspective, (7) analysis of problems in parallel perspective, (8) analysis of problems in angular perspective, (9) recognition of color. The norms are based on 1,100 pupils and are designed for use with children in grades three to twelve.

Often a parent brings a young child to the clinic for vocational guidance. Just as it is impractical to give vocational tests to children under fourteen or fifteen years of age because the children have no definite ideas concerning vocational possibilities, likewise it is impractical to give these children vocational questionnaires. Strong has pointed out that the younger the individual the greater the amount of change in interest, that therefore there is greater change of interest between the ages of fifteen to twenty-five than there is between the ages twenty-five to thirty-five, and that there is no way of determining how permanent an expressed interest is going to be. Most young children go through stages of wanting to be firemen or aviators. These interests, however, are usually not permanent. As children grow older their interests diverge into more fields but are still subject to change, although to a less degree. Therefore, it is only the



older children whose interest can be profitably studied by being given vocational questionnaires and tests.

Both Strong and Garretson have developed questionnaires. The former includes the study of the child's attitude toward many occupations. The latter is scored only for academic, commercial, and technical preferences. Knowledge of these broader preferences is probably all that should be taken seriously in children under sixteen years. The child indicates such of his likes and dislikes as various occupations, activities, personal qualities, and magazines.

The weight given to each preference has been carefully determined by the authors by finding out what percentage of those actually successfully engaged in the work had the same preference. The scoring method is objective and the norms are empirically derived.

However, it should be stated that these tests are limited in their use, and recommendations based on the results are given only with due consideration to the following: (1) that these tests are less valid than intelligence or educational tests; (2) that the presence or lack of interest, drive, and opportunities is a very important factor in determining the choice of a vocation; (3) that initiative and creativeness, which are not determined by these tests, are often important and necessary to insure success.

Thorndike and other investigators have stated that, on the basis of the tests alone, vocational success cannot be predicted in a high percentage of cases. The greatest value of vocational and special aptitude tests is achieved when the social, psychiatric, and physical findings are considered along with the psychological.

**Personality Schedules.** In addition to the vocational questionnaire, there are a number of questionnaires of personality traits which are helpful in the examination of the child. These are infrequently used in the clinic because they

are really adaptable only to older children. However, if given to a group of children they may indicate which children would benefit by a psychiatric interview and further study. In general they are not as valid as intelligence and educational tests and therefore must be used cautiously. The Thurstone Personality Schedule consists of 220 questions to which the subject responds by a "yes," "no," or "?." The following are samples of the types of questions: "Are you frequently worried about religion?" "Are you troubled with shyness?" "Does it make you uneasy to go into a tunnel or subway?"

The Bernreuter Personality Inventory contains 124 questions similar to those given above. It is scored for four different personality tendencies: self-sufficiency, introversion, extroversion, and dominance-submission. This inventory is more suitable to younger children than is the Thurstone.\*

## Summarizing the Psychological Examination

In reporting the findings for the staff conference the psychologist records all objective data and any observations which are incidental to the giving of the tests. He summarizes the findings of the intelligence tests, relates them to school placement and expectancy, points out discrepancies in achievement, describes special handicaps, and in general terms gives the results of the vocational tests.

It is the psychologist's function to interpret test results to school principals and teachers and parents and work out a plan for the child which will most fit his needs. It may take the line of special tutoring or appreciation of intellectual handicaps and a revision of school program, a promotion or more difficult work. Whatever it is, it should give the school

\* Other inventories such as Bell's Adjustment Inventory and Brown's Personality Inventory for Children which are similar to those already mentioned are also available for clinic use.

a more adequate understanding of the individual child and his capacity to learn and get ahead where this is possible.

The psychologist can be of service in the child's educational problems even before the child starts to school by determining approximately the most suitable time for him to enter first grade. Although six years is the usual age for starting school, in the case of some children it is advisable to postpone school entrance. If a child's mental age is much less than six, the first grade work may prove so difficult for him that his first school experiences are extremely unpleasant and may hinder his later school adjustment. The same child entering school a little later when his mental age has reached six would be more able to do the work and would have a greater chance of becoming a satisfactory, even if somewhat slow, pupil.

## Chapter VIII

### THE RECREATION STUDY

**I**N the early days of the Institute for Juvenile Research the play needs of children referred for study received little direct attention. Recommendations, when made, were general in character, as "membership in a supervised play group" or "recreational outlets." If one pauses to consider the emotional value with which play is charged for children, this failure to think more discriminatingly about play needs appears at once as a serious oversight in any careful study of childhood.

The matters of primary importance to adults in relation to children are likely to be standards of conduct, school achievement, and health. These same matters are considered for the most part by the child in the light of whatever concessions he must make to his parents' views if he is to be on good terms with them. Material provisions, food, clothing, and shelter, concern over which is an almost constant adult preoccupation, are taken for granted by the child. But he does not fail to note any evidence of adult interest in his play. Whether the parent's interest or that of any older person is expressed in actual participation in the play or merely in patient listening, it often takes on significance for the child far greater in proportion than any effort which the adult puts into it. This is particularly significant if one thinks of the proportionately greater amount of time and thought adults expend on providing clothing and food for their children—efforts which lead to little or no appreciation from them. The primary rôle of play in the emotional life of

the child is illustrated by the fact that family problems, such as illness of a member of the family or financial stringency, take on vital meaning for him when they operate directly or indirectly to limit his opportunities for having a good time.

Numerous theories have been advanced to explain the phenomenon of play. Of these the Schiller-Spencer surplus energy theory; the Groos practice theory of play; the G. Stanley Hall recapitulation theory; and, more recently, the Freudian theory of compensation for unsatisfied instinctual urges, have perhaps received the widest discussion.\* Any of these theories, if considered individually, represents but a partial explanation of the complex phenomenon of play. Each recognizes, however, that play expression is intimately related to all other phases of life, both individual and collective.

The same strivings which characterize other aspects of life such as the desire to feel or test one's powers and the desire to win social approval are frequently observed in the play situation. Because adult authority is less in evidence in this than in other aspects of children's lives, these motives have greater freedom in play. It is this freedom from adult direction and criticism which is for most children the implicit characteristic of play. If adults are involved they are participating not as adults, but in rôles assigned to them by children.

It is clear that play is only relatively freer than other pursuits in which children engage. Their own emotional needs and standards which have been taken over by them from adults and their companions operate always to influence the form which play expression takes and, unless the

\* Harvey C. Lehman, and Paul A. Witty, *The Psychology of Play Activities*, Chapter 11, "Theories Which Seek to Explain Play" (A. S. Barnes & Company, New York, 1927).



activity is a solitary one, to discipline the participating players.

In play the child may be said to be seeking satisfactions in his own terms, within the limits set by his physical, intellectual, and emotional development, and the social setting in which he moves. The tendency of some persons to fail to recognize the importance of all of these elements and to view play as a thing apart from other phases of life has led even professional recreation workers to standardize recreation thinking and to plan in terms of adult conception of children's desires and needs for proper development.

The consequence has been that many children with irregular development or special handicaps, physical, intellectual, or emotional, cannot find satisfactions through established recreational agencies or programs. It is children such as these that one sees frequently in the child guidance clinic. Study of them impresses one with the fact that the play desires and needs of one individual may differ greatly from those of another even of the same age. Although play needs cannot always be so easily described as physical needs, they are nevertheless for each person individual in character.

The recreation service has been primarily concerned with the exploration of recreational interests on an individual basis to see how individual differences operate to determine the form which play expression takes. Concern has been less with the particular play activity as such than with its meaning for the developing personality and the possibility of directing the interest toward emotional growth.

Some fifteen years ago, at the time this specialized work in recreation was begun, the case work field furnished little precedent for the exploration of individual recreational interests, especially with children, and the group approach in the field of recreation was not suited to the clinic where individuals have little in common except that they all have

behavior difficulties. A method for interviewing children about their play had, therefore, to be developed.

Early efforts to talk to children about their play revealed that casual inquiry by adults rarely yields much of significance. Children's replies tend to be equally casual. To bridge the gap between adults and children, likely to be widest when play is the subject under consideration, and to facilitate the securing of pertinent data about recreation as an aid to careful planning for the child, more thoughtful procedure was necessary.

After a period of experimentation, recreation outlines for different age groups began to assume a fairly definite form. These provided for more detailed exploration of interests and play experience than was characteristic of the social worker's or psychiatrist's inquiry into such matters. The "recreation interview," as the method has come to be called, is now an integral part of the clinical examination.

At the present time there are three recreation interview forms, one for children nine to fifteen years, the second for adolescents above fifteen, and the third for adults. Because the outlines are used flexibly, they are not suitable for statistical investigations which involve uniformity in the questions and directions.

To judge from the experience at the Institute for Juvenile Research, little is to be gained in the interviewing of children under nine years of age. With young children emphasis tends usually to be upon action rather than reflection, and, in the investigation of their play interests, observation is regarded as a more reliable method than conversation. There are, however, exceptions to the general rule, chiefly with children of superior intelligence, who can often be interviewed successfully at seven or eight years.

In conducting a recreation interview, the outline suitable for the child's age is employed, not as a questionnaire, but

as a guide for conversation. When approaching a child for the interview, the explanation made to him is that the interviewer is engaged in making a study of the way in which to have a good time, since what constitutes fun varies from person to person. The child's right to his own definition of a good time is emphasized, and the point made that his opinions are being solicited not only as a contribution to the study but as a means of getting better acquainted with him. The subject-matter is one that the usual child considers of vital importance, and interest is ordinarily aroused easily. The necessity to record answers to avoid confusion with other children's replies is stated and is usually accepted without questions.

Following a brief explanation of this type, the interviewer sets about to secure as comprehensive a first-hand account as possible of the way in which the child spends his leisure time, with the emphasis placed upon attitudes both positive and negative toward various recreational activities and toward persons related to his play. Children may be self-conscious for the first five or ten minutes, but later the interview becomes for most of them an enthusiastic account of good times.

In the course of talking to a child about his play, attention is focused first on the opportunities for good times provided by the parents in terms of toys, games, outings, and other forms of family play. With a single question such as "Do you ever have any fun at home?" the interviewer is often able to distinguish between a tense and a congenial atmosphere and to get clues as to the way in which different members of the family feel about each other. For example, one child replied to this question "Sure! My father jokes with my mother and then we all laugh." Frequently quite another picture is obtained. "My mother's always working and in the evening she goes to parties." Parents often regard the

activity shared with children as play when apparently it is not so regarded by the children. An eight-year-old boy remarked, for example, "Of course my mother takes me to the movies, you might call that play. She sits next to me and always wants to whisper the story to me."

In the play life of children, particularly those under eleven or twelve years of age, toys have an important rôle. They appear to have significance, notably in relation to the child's developing interests, but also from the standpoint of their comparison in quantity and quality with those of his immediate associates; such considerations markedly affect his status with other children. Information is sought, therefore, not only about the actual extent of his possessions and the use made of them; the inquiry concerns itself also with his wishes in this direction and the child's attitude toward his material advantages as they compare with those of his companions. A twin boy nine years of age said, for example, "My brother has more than me; because he was sick most of the time, he got most of the presents." To the casual observers their possessions seemed equal in amount.

During the interview attention is focused on the detailed exploration of interests; on the reasons advanced for game, movie, or reading preferences; and on the obstacles to participation in fields in which the child expresses interest. Often these are set by parental prejudices. Many small boys, for example, are denied guns because of the fear that play of this type may stimulate or accentuate asocial tendencies.

From accounts of make-believe play, original stories, and reading and movie preferences, one often secures significant clues to the child's subjective world. An eight-year-old girl, jealous of a younger sister ill in a hospital, describing her doll play, said, "Since I got this last doll, I play like she's real delicate so I can spoil her." A bright but repressed fifteen-year-old girl who designated "The Vikings" as her



favorite movie expressed a wish to have lived in another age. "There is something superficial about the age in which we live. I like the Vikings because they gave vent to their thoughts and feelings without restraint."

The recreation investigation deals also with the child's relationship to other children, particularly from the standpoint of influences at work in the neighborhood. The attitude which a child expresses toward his neighborhood is often indicative of his acceptance or non-acceptance there, particularly when it is interpreted in the light of possibly conflicting data from other sources. The boy who gives as the reason for his dislikes of the neighborhood the fact that "There are only little kids there," may be giving expression in this way to his feeling of social isolation. Details are solicited concerning the nature and extent of the child's association with other children, the places where they meet, as well as any relationships to existing play groups, both spontaneous and supervised. For example, if a boy reported being a member of a Scout Troop the interviewer would seek to discover the number of the troop, the length of membership, attitudes toward the leader and other members, as well as progress in meeting the requirements for advancement from rank to rank.

The information obtained from the child in a recreation interview cannot always be accepted at its face value. It must be interpreted in the light of his general pattern of response in this and other examinations, the findings of other examiners, as well as reports from those who are in a position to observe his play at first hand. If a child says that the other children are more fortunate in the matter of toys, have more spending money, are more skillful in activities, that is, if he consistently pictures himself in an unfavorable light, this may suggest a tendency to self-depreciation which should



be dealt with rather than his story of specific deficiencies, which may have been exaggerated.

The reverse tendency, that of boasting excessively, may also present itself, either as a general response or in relation to particular types of questions, for example, in those relating to material possessions or skill in games. A twelve-year-old boy, interviewed when he was recovering from an attack of encephalitis, spoke enthusiastically of his football team and the way in which all of the members "chipped" together to buy the ball which he was allowed to keep in his home. This boy actually spent his time playing jacks and simple ball-bouncing games with an eight-year-old sister, but previous to his illness had participated in the team sports of his neighborhood. The degree of his disappointment can be understood from his attempts to present a more acceptable picture to the interviewer.

Although it should perhaps be emphasized that the recreation interview is not used specifically to probe into the child's personality difficulties, much that bears on that problem may come out indirectly. The result may be some duplication with the psychiatric interview, especially in view of the fact that the psychiatrist may also question the child directly about play. However, an attempt to avoid duplication is made by both staff members. If the psychiatrist is aware that a recreation interview is to be given, less of his attention will be concentrated on these matters since he knows they will have careful exploration from another source. The recreation worker, on the other hand, does not take any initiative in exploring the basis of the child's emotional difficulties. Related material which is spontaneously expressed is accepted and passed on to the psychiatrist along with observations of behavior and attitudes revealed in the discussion of play which may have a bearing on his emotional problems. The disadvantage of possible duplication

is thought to be balanced by the advantage of having the observations of another examiner who has greater familiarity with the field of play activities and resources.

Occasionally one encounters discrepancies in the play information given to the recreation worker and the psychiatrist. They may be explained by the differences in sex or personality of the two interviewers or may furnish evidences of conflict in the child. First, however, allowances have to be made for over-statement or under-statement, and the child's account must be verified by comparison with reports of play leaders, teachers, parents, or by direct observation to check the child's report against his activity during his leisure time. The next step is the evaluation of his play problem in the light of the findings of the physical, psychological, and psychiatric examinations, as well as the opportunities and limitations of the social situation in which he is placed. The recreation study, therefore, involves not only careful individual consideration but an appraisal of family and community resources from the standpoint of the child's specific play needs.

With many children seen in a child guidance clinic, individual deviations, physical, intellectual, and emotional, operate to interfere with a satisfying recreation adjustment. Aspects of the child's physical condition are among the most obvious factors calling for consideration. The child disabled by infantile paralysis is clearly unable to compete with other children in active games, but a child markedly over-weight or one with a serious cardiac condition or poor muscular coördination may have equal or even greater difficulty, in fact, additional problems. The less obvious character of his handicap may make it not so understandable to the other children and fewer allowances may be made for him. For the child who is unable to prove his usefulness to the neighborhood or school group in physical activities, it is necessary

to discover other fields of interest and abilities through which satisfaction may be derived and a kind of status attained. Although in recent years special attention has been given to the recreation needs of the handicapped child, this work has pertained largely to groups of physically handicapped in schools or institutions. There has been developed some material which can be drawn upon in giving suggestions to parents, but with the child seen in the clinic the problem is essentially one of discovering and strengthening personal resources, since special recreational programs for the physically handicapped are not available in local neighborhoods. If given help in developing manual and artistic skills or more subtle personal ones, the physically handicapped child is often able to maintain a satisfactory position with children not so handicapped.

The child who deviates from the intellectual level of his group likewise has special recreation problems. If he is less bright he usually has difficulty in keeping up with those of his chronological age in street play and he is especially at a disadvantage in highly organized groups such as the Scouts. In order to progress in this organization he must pass prescribed tests many of which demand performance likely to be beyond his ability. Because recreation programs adapted to the special needs and limitations of this group are almost wholly lacking, many retarded children occupy isolated positions in their neighborhoods or become allied with delinquent gangs, frequently being used as tools.

Retarded children with intelligence quotients from 70 to 90 who are ordinarily not committable to special institutions for the mentally retarded present the greatest challenge from the standpoint of recreation. The difficulty for the recreation agency is that there are often not enough such children in the immediate neighborhood to make it possible to organize special groups in which the program can be adjusted to the

slower pace of their development. Experience has shown that while the mentally retarded are definitely handicapped in the play activities dependent upon the higher intellectual functions, such children may develop considerable skill in manual and physical activities. A group of boys in a special institution for the feeble-minded, for example, with a median mental age of nine years and eleven months and a median I.Q. of 62, were able to master the complex game of basketball and compete satisfactorily in a tournament with regular Junior High School pupils when coaching methods which took account of their intellectual limitations were emphasized.\* In the absence of special play groups for mentally retarded children, there is sometimes the possibility of satisfactory group experience with younger children of comparable mental development. When the child is physically retarded as well as mentally retarded his social adjustment is less difficult.

The gifted child, like the retarded one, is likely to have difficulty in adapting to the spontaneous play groups of his neighborhood, through which skill in social relationships is developed, and thus has peculiar problems. For example, if he is three years in advance of his contemporaries mentally, their games and activities will in all likelihood seem "babyish," their puzzles and tricks too obvious for him, and presently he may be regarded as a snob. His intellectual development is more in keeping with that of an older group, but they may not accept him because he is too small physically to be of much use in their games. If he persists in hanging around he may gain the reputation of being a nuisance, unless, of course, he is able to make a contribution to the group despite his physical size.

\* Bertha Schlotter, and Margaret Svendsen, *An Experiment in Recreation with the Mentally Retarded* (Behavior Research Fund, Chicago, 1930). Witty and Beaman, "The Play of Mental Deviates," *Mental Hygiene*, October, 1933.



Hollingsworth \* has observed that for the most part children with intelligence quotients between 130 and 145 show the usual play interests of their age. It is only above this level that they appear conspicuously different. If these children are carefully guided in the social aspects of their training, they succeed in establishing themselves with others of their own mental age. This suggests that gifted children need not suffer social isolation, but there is an evident need for an evaluation of present practices in the recreation field with reference to their particular needs. Observations in the clinic point to a tendency on the part of workers in settlements and other group work agencies to stimulate achievement along individualistic lines in the very bright child who comes to their attention, particularly if he is personally ambitious. This practice may prove destructive by accentuating in such an individual a feeling of social isolation from his family and the neighborhood.

The fact that a child has been referred to a behavior clinic suggests certain attitudes of his own that need to be considered. Because of previous failures in social adjustment and greater feeling of insecurity than many children of the neighborhood, he may require more encouragement than the average child in his pursuit of activities and particularly in his attempts to improve his relations with his contemporaries. There are some children so insecure emotionally that a close supporting relationship with a psychiatrist or some other presumably mature adult must precede any recreation considerations. One child who was in need of this type of supporting relationship was a twelve-year-old self-conscious girl who had a tendency to think of herself as a bright and talented person. She had a number of definite interests, reading, drawing, acting, typing, and was eager for a career along

\* Leta Hollingsworth, *Gifted Children*. (The Macmillan Company, New York, 1929.)



artistic lines. In speaking of this ambition she remarked, "That's one thing that's the matter with me, I act so much people ask if I'm sincere." This girl lived with her father and seventeen-year-old brother. The mother was in a State hospital. She had no friends or companions and had serious doubt of her ability to secure them. She was at the time of the examination about to enter high school. "I might make friends there," she said, then after a pause added, "You know you do," by way of reassuring herself, clearly doubting as she said it that she would be successful. The objective in a supporting relationship should be to prepare her gradually for participation with her contemporaries by diminishing her fear of people through the experience of a satisfactory relationship with an adult.

The effect of various aspects of family life and attitudes on the child's play needs to be examined. Parents who were deprived of opportunities for play in their own childhoods may overwhelm their children with play equipment and incitements long before they are ready for them and thus deprive the children of the chance to make choices or exercise initiative. In marked contrast is the parent who sees no value in play because he never played as a child. The child of such a parent may be expected to "improve every shining hour" with cultural or intellectual pursuits tending toward great achievement and renown. In between comes the parent who recognizes play as a moderately valuable occupation, either because it keeps children out from under foot or off of the streets, but who lacks discrimination about the comparative value of various types of recreational experience.

Religious convictions or racial attitudes also enter into the determination of recreational opportunities. For example, a Jewish girl who wished to attend classes at a center sponsored by a non-Jewish group brought down upon her head the wrath of an orthodox father. And there was the boy

whose Roman Catholic parents forbade his attendance at the Y.M.C.A.

National customs must likewise be considered. Among Italian and Mexican families where old-world traditions prevail, no "nice" adolescent girl is permitted out of the home in the evening even to attend the settlement which she frequents by day. Whatever the prevailing nationality in a given community, a child belonging either to a group so markedly in the minority as to be conspicuous for this fact or to a group which is increasing in size with sufficient rapidity to threaten the control of the predominating one, will have his recreation and social adjustment colored by these facts.

Educational and social differences enter to complicate matters further, for families with traditions to maintain often feel it degrading to permit their younger members to associate with so-called inferior individuals, often thereby depriving the children of opportunities for companionship with those of their own age. Adolescents, in particular, often find it difficult to meet on a common basis for much social intimacy with those of a markedly different educational or cultural background.

Economic considerations play a most important rôle in recreational experience. Lack of money for membership fees, dues, car-fare when the play center, park, or other facility is at some distance from the home, serves to limit opportunities for many children seen in the clinic. In this connection the amount of spending money or spending allowance received, particularly as seen in relation to that received by his immediate associates, becomes for the child a matter of vital concern as often does any deviation from group standards in matters such as home furnishings, clothing, the possession of a house key, or permission to use the family car.

Community trends and practices also exercise their in-

fluences upon an individual's recreation adjustment. In sections where the gang pattern prevails, a boy who is not a member is likely to be as much a deviant as would be a gang member in a neighborhood which frowned upon such activities and shunned a boy who participated. In a community where athletics and sports are glorified above all else a boy without physical skills, whose interests are primarily in scientific pursuit, may have little opportunity for the social contacts he needs for balance. In similar fashion, the daughter of socially ambitious parents, who expect her to spend all her free time in the purely social activities, may present a serious problem to herself and her family if she persists in following seriously her interest in professional dramatics.

To help a child harmonize his individual interests with community patterns calls in many instances for great ingenuity and the coöperation of agencies operating in the community is usually necessary. The Recreation Service at the Institute keeps on hand a map showing the chief recreational facilities of the city in order to locate quickly resources in the child's immediate neighborhood.

It has sometimes been said that mental hygienists place a premium on extroversion, setting as the goal for development, the ability to adjust and find satisfactions in a group. There is little doubt but that many significant contributions to society have been made by persons who would have to be described as solitary. The objective is, therefore, a socialized attitude rather than physical presence in a group. There is no attempt made to force group placement upon a child if the wish for such experience is not present, even if he may appear to need broader contacts. Steps may be taken, however, to awaken a desire for more friends.

This desire or the wish to join a club is often expressly stated during some part of the examination. Sometimes the specific type of group, such as Boy Scouts or the Y.M.C.A.,

may be mentioned. With other children membership in some such organization may be suggested by the interviewer to meet a vague longing for more exciting experiences. Not infrequently the suggestion is eagerly grasped by the child. Any uncertainty or misconceptions regarding the requirements for membership are then cleared up or additional information is given. Sometimes the idea must be presented first to the parents and their approval gained.

The attitude toward specific recreation agencies is an important factor. Delinquent boys, for example, frequently consider the Boy Scout program to be for "sissies." In one case a child resisted all efforts of the worker to interest him in a certain boys' club in the neighborhood in spite of the fact that it alone had the facilities compatible with his expressed interests. It finally developed that the friend of his older brother, whom this boy strove to emulate, had characterized the place as "lousy." Neither of the boys had had any actual experience with the boys' club.

When community recreational facilities in urban centers, where most child guidance clinics are located, are viewed from the standpoint of the child having difficulty in social adjustment, the following general observations may be made. First there is a scarcity of supervised recreational facilities in many neighborhoods. Then supervision is usually imperative for the children brought to the clinic because of their failure to establish themselves in the free-lance play of the neighborhood. Their general insecurity in social relationships makes the more personal factors, the personality of the leader, and the stage of development of the other children in the group more significant determinants of their adjustment than are the particular activities actually being promoted.

The fact that the programs of the established recreation agencies (as the public school programs) have developed,



for the most part, around the needs of the average child, means that many children in every neighborhood are neglected. These tend, as already indicated to be those who deviate from the norm in some respect, physically, intellectually, or emotionally.

There is some evidence from clinical study that the established group-work programs, national in scope (the Boy Scouts, Girl Scouts, and Camp Fire Girls), attract a somewhat selective membership, both in terms of intelligence and family background. This is unfortunate because in some neighborhoods they represent the only available supervised groups, and their programs are not suited to the needs of all of the children in a neighborhood, even within the age range which they serve. One might go so far as to say that in some neighborhoods they do not meet the needs of most of the children. This is particularly true in areas with a high rate of delinquency. The Scout program, for example, comes to represent for children in such areas a norm of acceptable social behavior to which they do not wish to conform. Often too in neighborhoods of low economic status the cost of joining such organizations makes membership prohibitive.

If one considers availability of recreation resources in relation to the factor of chronological age, it is clear that certain age groups are more neglected by recreation leaders than others. Opportunities for participation in group play under supervision with others of their own age are still rare for children under ten years of age. The assumption has been that it is not until early adolescence that the child needs this type of experience. There are some educators who question the wisdom of organizing the activities of children younger than ten or twelve years. The size of groups for small children might be open to question in many cases. With schools operated for the most part along individualistic lines, however, and particularly where there is only one child



in the family or a wide age gap between siblings, it is often not enough to rely upon the voluntary associations of children to iron out the difficulties which any girl or boy may have in establishing social contacts. There is evident a movement on the part of executives of summer camps and other recreation agencies to establish facilities for younger children and to extend those which already exist. Settlements begin with nursery schools; the Boy Scouts operate Cub Scout Packs for which boys are eligible at nine years; the Girl Scouts have Brownies with a minimum age requirement of eight years. The Camp Fire Girls have Bluebirds with a lower age limit of six years. Certain Y.M.C.A. branches now admit boys to membership at seven years of age. The actual number of groups for younger children is still limited, however, by comparison with opportunities for the early adolescent boy or girl.

In the residential sections of our cities there is often a scarcity of organized groups for adolescents beyond fifteen or sixteen years of age. The settlements meet this need to some extent in the congested areas. In the sections mentioned, however, there is often nothing in the immediate community for the girl or boy when interest wanes in such organizations as Boy Scouts, Girl Scouts, Camp Fire Girls, which it usually does at fifteen or sixteen years of age. For individuals whose interests are primarily athletic, there are the public parks and playgrounds. Usually other interests can be satisfied only if there is a church which has a vital young people's program or when there is a school community center, a Y.M.C.A. or a Y.W.C.A. branch nearby. In recent years there has been some attempt to extend the scope of the park and playground programs for adolescents to include a wider range of individual hobbies and mixed social activities.

On the whole the needs of adolescents generally and so-

phisticated adolescents in particular, both non-delinquent and delinquent, are inadequately provided for. Many self-organized groups undoubtedly exist, but these are not catalogued and are not available for use in the social treatment of adolescents seen in the child guidance clinic. Even were knowledge of their location at hand, there would still be the difficulty of arranging membership for a stranger in an exclusive and well-established group.

The same factors operate to an even greater extent for adults. Yet the need for parents to find interests outside of their home and children is often urgent in cases known to the child guidance clinic. Programs sponsored recently under Federal subsidies are affecting the general recreation situation to some extent by increasing informal educational and recreational facilities for adolescents and adults.

When attempting to aid the individual to achieve more satisfactory recreation, it is found that certain features of group work programs themselves are as difficult to cope with as the scarcity of facilities. A good deal of attention has been drawn recently to the ready-made, moralistic, and mass character of many recreational programs. These operate on the one hand to mould those served into the same pattern, but on the other hand, and more important from the standpoint of the child guidance clinic, to deprive the girls and boys most in need of socializing influences of the opportunity for group experience of a constructive type.

With the child seen in the clinic, even more than with the average boy or girl, the point of departure in any program directed toward his development, must be the interests and attitudes prevalent at the time. The reasons are obvious. Exaggerated mistrust of people leads to an excessive fear of not being able to measure up to their standards and hence a reluctance to enter into new activities or to join with strange children. Only in those spheres

where some degree of confidence has been established previously can such a child be encouraged to venture further.

The last few years have brought some lessening of the earlier emphasis in recreational programs upon competitive enterprises, but stimulation of interest in competition along individual lines, through merit-award systems which serve to accentuate asocial tendencies, still characterizes much effort in the recreation field. This fact, together with the narrow range of activities offered in some of the centers, makes it difficult, particularly for children who show deviations in abilities or irregular development, to find group connections in line with their interests. Many programs are still set up in terms of adult objectives and follow a preconceived plan, instead of being orientated in relation to the changing interests of developing children. The gap between what is offered by the recreational center and what the child has experienced and wants is often too wide for him to bridge.

Children seen in the clinic have for the most part clearly defined interests. These may be highly concentrated and somewhat atypical when compared with the activities of most of the children in the neighborhood or with the programs sponsored by recreational agencies, again serving to make it difficult to find a suitable group into which to introduce a particular child. It is a difficult task through the medium of the existing recreational agency to prepare the way for wider social participation for the boy who lacks skill in establishing personal relationships if, for example, the child's absorbing interest is chemistry or mechanics.

This raises the question of the extent to which the group-work agency should duplicate the equipment and activities of the schools. The fact is that, despite instruction in school in such subjects as cooking, sewing, woodwork, electricity

and radio—sometimes perhaps because of it—such activities are frequent leisure time occupations. In some instances the subject does not appear in the curriculum until several years after it emerges as a spontaneous interest. At the age of ten or eleven years, for example, many boys are interested in experimenting with a chemistry set, yet opportunity for expression of this interest is not possible until the senior high school. Because of the greater flexibility of the settlement, the summer camp, and the Y.W.C.A. programs and the fact that in these agencies activities are carried on in small, relatively stable groups, they have been found by the Institute to be the most satisfactory for children seen in the clinic. In a few instances, because of the difficulties involved in trying to fit stray individuals into existing groups, recreational agencies have coöperated by establishing special groups around the interests and needs of individuals who deviate. Where this has been done, membership in the regular classes or clubs has sometimes been possible later. For the most part, however, the prevalence of volunteer leadership and the large number of children in attendance at any one recreational center preclude this amount of individual attention. In the training programs for recreational workers there is still the tendency to place greater emphasis upon activities and skills than upon the understanding of personality development. This means that even the trained worker is often not equipped to deal with the difficult child.

Serving as something of an obstacle in the use of recreational facilities, particularly with adolescents, is the fact that organized recreational programs tend to follow sex lines. Boys' work and girls' work are carried on to a large extent by separate agencies or, if within the same building, in different departments. A number of agencies of which this has been



true in the past are, however, experimenting in the field of coeducational activities.

Despite all of the factors outlined above which may serve as obstacles in the use of existing recreational facilities for "problem" children, recreation leaders are found usually eager to coöperate on individual cases within the limitations of their staff and facilities. Conferences are often arranged between workers of the two agencies to appraise the situation and to make such modifications and concessions as are possible. In some instances this involves providing a scholarship, in others coöperation has gone to the point where special groups have been organized around the needs of one or more children with such special difficulties as extreme shyness or mental deficiency.

One of the most serious obstacles to effective work in the field of child guidance is the lack of integration of the work of the recreational agency with that of the home, the school, and the clinic. As an outgrowth of the difficulties of trying to link "problem" children with the facilities in their neighborhood and to combat the lack of knowledge in one agency of what other institutions or organizations are attempting to do with the same child, experimental neighborhood projects are now under way in a number of cities. In general these have as their objective the development of a recreational program based on the needs and interests of the children themselves and, as a further goal, the integration of all of the educational and social services in the local area.



## Chapter IX

### THE PSYCHIATRIC INTERVIEW

WHEN a group of people work together on the same problem it is inevitable that some overlapping of interest and method will be disclosed. This is found to be of much more theoretical than practical importance, but it should be understood that the following discussion of the methods and contribution of the psychiatrist applies in part to the work of others in the group.

In the total effort to understand the causes of the child's behavior, the special contribution of the psychiatrist is the discovery and elucidation of the child's inner motives as these are revealed by his behavior in the situations in which he is placed. In simplified and popular language these motives can be termed emotions. It is convenient, although not wholly accurate, to say that, in the child guidance clinic at any rate, the clinical psychologist is concerned primarily with a study and evaluation of the child's intellectual functions while the psychiatrist is primarily concerned with the study of the emotions. It is perhaps unnecessary to point out that the word is not used here in the sense of strongly exhibited dramatic emotions. In fact, a phlegmatic disposition or a completely colorless response to a situation may be as truly indicative of the inner motivation of the person as an hysterical outburst.

It is obvious that human motivations are never observed directly. They can only be inferred. From early childhood all of us attempt to make such inferences concerning the dispositions of our friends, basing them on what we see or

are told. These judgments are based partly on past experience with other people and partly on knowledge of our own motives and the way in which we act upon them. The thing which the psychiatrist does is no different in kind from that which all human beings (except complete recluses) do every day in their lives. The psychiatrist by his training is simply prepared to make more systematic and thoroughgoing inferences. He employs the same foregoing two methods that everyone else does. He sees, in the course of his training and practice, many people who are in need of help and therefore willing to lay before him, more freely than most people, the inner needs and urges of their lives, and in the course of his training he also undertakes a much more searching examination of his own urges than most people do.

Since motives are a matter of inference and not of direct observation, the psychiatrist could conceivably make his contribution on the basis of the observations of others without having any personal contacts with the patient at all. In fact, this occasionally is done in some clinics. The social history is, of course, a detailed summary of the child's behavior and is at its best when it contains a good many specific instances of this behavior. When they are well reported they furnish very good material upon which to base psychiatric inferences. The contact between the child and other members of the clinic staff also, if well reported, will give material upon which a psychiatrist can base fairly good inferences. However, the observations of others cannot wholly take the place of direct observation by the psychiatrist. This is particularly true in the realm of behavior because we have an extremely inadequate means of reporting that behavior to a third person. If the narrative is kept entirely objective and yet adequate in detail it becomes so cumbersome as to be meaningless. In order to avoid dreary

reams of narrative description, the social worker is compelled to use terms which are based in part upon her own interpretations of the motive back of behavior. The worker can say "the child answered in an angry tone of voice" and give a fairly vivid impression of what happened, but, were she to attempt to describe the voice in terms of pitch and quality, the result would be almost meaningless. Yet the word "angry" is an inference drawn from the worker's actual observation. The effort is constantly being made in mental hygiene clinics to develop descriptive terms which will be without diagnostic implications and, where this is not achieved, to train all observers to use terms which do imply interpretation in a consistent manner. In spite of this, however, the personal equation cannot be eliminated; when the psychiatrist is dealing with records exclusively, he has to make allowances not only for his own preconceptions and prejudices but for those of the social worker as well. (He has in addition to make allowances for his own preconceptions and prejudices about the worker who reports the case.) Consequently, the psychiatrist wishes to make direct observations upon the child as well as to work with the reports which are made by the other workers.

Furthermore, the psychiatrist acquires special methods which encourage the child to speak or behave in ways which are especially revealing and thus increases the amount of useful material from which to make inferences. Some of these methods will be discussed later in this chapter.

As a result of his training, the psychiatrist has another definite contribution to make to the staff study. Psychiatry is a medical specialty, and before beginning his special training the psychiatrist must have the foundation of a general medical course. Reference has already been made to the rather prevalent tendency either to ignore the influence which the child's physical condition may have upon

his behavior or else to consider physical conditions to the exclusion of everything else. The psychiatrist is strategically situated to take both viewpoints into consideration, and it is on this account that he acts as chairman of the staff conference as mentioned in Chapter IV.

It is rather widely held that the psychiatrist sees every trouble as mental. This is by no means true. Not infrequently in obscure conditions where the diagnosis is in dispute the psychiatrist will be found arguing that the condition is basically organic while the pediatrician or neurologist will maintain that it is entirely functional. Furthermore, in certain obscure conditions the facts about the personality which the psychiatrist determines in the course of his examination may be finally decisive in determining the diagnoses. For example, major hysteria and epilepsy at times show physical symptoms which are indistinguishable and the diagnosis depends upon whether or not the psychiatrist finds the hysterical reactions and mechanisms or the so-called epileptic personality in the course of his study. It follows that the foundation of knowledge and experience in dealing with bodily diseases and injuries remains important to the psychiatrist's work, though in some of his functions he seems to be wandering far from general medicine.

The psychiatric interview has another value which is absent from the reports of the child's spontaneous behavior in his natural environment, a value which is not obvious at first view. Parents and others dealing with a child frequently ask the psychiatrist: "How can you get any idea of what he is like down here in strange surroundings? You really ought to see him in his own home to understand him." It is true that, if inferences were drawn entirely from the child's behavior in the clinic, many extremely important facts on which to base such inferences would be left out.



On the other hand, the natural environment of every child is unique and this makes comparison of the behavior of one child with another a difficult and only approximately accurate affair. In the psychiatric interview, much more than in most situations, other factors are kept constant and the behavior of one child can be compared directly with that of another. Neither of two children may behave at all as he would in his own home, but if they behave differently in a situation which is essentially the same, that difference in behavior is of itself significant. In the long run the psychiatrist acquires a background of knowledge of the way children behave in this unique situation which is of considerable value in judging each new child.

On the other hand, the psychiatric interview differs from the other examinations at the clinic, in degree at least, in that the child is allowed to be more spontaneous than in other situations. He is encouraged to give his own account of his attitudes, motives, conflicts, and other inner states. This affords the psychiatrist an opportunity to observe his manner, blocking, tensions, responsiveness, and many other things, besides the content of his speech, which furnish clues to his ideas and emotions. An adolescent girl in the course of treatment gave evidence of a healthier attitude toward social contacts by appearing with her stockings carefully drawn straight instead of in haphazard spirals as formerly.

Finally, the psychiatric interview has as its purpose the opening of the way for later treatment interviews if it is decided in the staff conference that this is called for in the particular case.

In dealing with the behavior of a child it is important not only to understand his motives but the motives of the adults who are intimately associated with him. It is well to remember that motives are frequently hidden. For reasons already mentioned the psychiatrist welcomes the opportunity



to have interviews with those adults who are in close contact with the child. The foregoing considerations apply equally well to interviews with adults who are responsible for the care of the child.

There are no standardized methods or techniques in the psychiatric interview. The core of the whole thing is the attempt on the part of the psychiatrist to encourage the child to a spontaneous, untrammelled expression of his own attitudes. To maintain this spontaneity the psychiatrist's rôle is one of continuous improvisation, employing one method or another as it may appear to be best suited for the situation at hand. Instead of one method, numerous methods which can be combined in various ways may appear necessary.

The setting in which the psychiatric examination takes place is of some importance; it is not always given in the office. Occasionally the psychiatrist feels that it would be better to talk to the child in the playroom where he is busy with playthings. With young children especially or with those who are retarded in their intellectual development, there may be no interview technically so-called, but the psychiatrist may simply observe the child in his play and relationship with other children. In some clinics the psychiatrist makes such observations of the child on the playground, in the classroom, or in his own home. These observations have the advantage that the child is in his natural setting, but the disadvantage already mentioned, that they are less controlled.

For the most part, however, children are taken to the psychiatrist's office for a more formal interview. The psychiatrist may introduce himself and conduct the child to the examining room or he may arrange to be introduced by someone else. Except in very rare instances, the psychiatrist interviews only one person at a time. The value of the interview to a considerable extent depends upon placing a child

in a very simple situation. A third person in the room complicates this situation to a quite undeterminable degree.\*

The room where the examination is conducted should be pleasantly but unobtrusively furnished. The light should be arranged so that it does not fall in the patient's face, and if someone must face the light it should be the psychiatrist, as this gives those older patients who feel that the psychiatric interview is something of a contest in wits, some initial advantage. The patient should be provided with a really comfortable chair in which he can relax thoroughly. Some psychiatrists prefer to have patients recline and may feel that frequently it is helpful to place the patient in such a way that he is not facing the doctor. Decorations should be pleasant but so unobtrusive that they do not tend to attract attention, and there should be little in the room except what will actually be used in the examination. When play techniques are employed the playthings should be readily at hand. The furnishings of the room should be arranged in any case to provide for thorough physical comfort and a pleasing but not distracting appearance.

When the child and the psychiatrist are in the office together, the latter attempts by various means to encourage the child to give a spontaneous expression of his attitudes and ideas. The approach will differ decidedly, depending upon the age of the child and also upon the circumstances of his coming to the clinic. As a rule, it is necessary to do something to overcome the initial suspicion and hostility. Efforts are made before the first contact with the child to help the

\* Newton formulated a very simple mathematical equation which describes completely the behavior of two bodies in space reacting on each other according to his laws of gravitation. In the 300 years since Newton no one has been able to introduce a formula which would describe the behavior of three such bodies acting upon one another. In much the same way the interactions of two people together is almost infinitely simpler than the interactions of three.

parents explain the examination to him so that he will expect a friendly attitude and a wish to be helpful on the part of the clinic staff. In spite of all efforts this explanation is seldom entirely successful. The child, after all, does come to the clinic because he has caused anxiety to the grown-ups who are dealing with him, and almost inevitably he expects other grown-ups to take sides with his parents. More than once a child has explained his presence at the clinic by saying that his parents wanted to find out if he were crazy.

Under such circumstances the psychiatrist might be inclined to take sides with the child against the parents in order to convince him that his suspicions are unfounded. This, of course, is likely to stand in the way of the ultimate goal which is mutual adjustment between parent and child. Various means can be used to overcome the initial suspicious attitude. Since the psychiatric examination usually comes late in the day, the child has by this time been dealt with by other members of the staff and has found an interested friendly attitude throughout. Consequently, by the time the psychiatrist sees him his attitude toward the staff as a whole is generally much more friendly than at the beginning of the day.

With young children who do not have clear ideas about the examination and its purpose but simply a vague feeling that it is one more method to put them in their place, an indirect approach is usually the best. The psychiatrist encourages the child to talk about neutral topics, his interests and games. This serves two purposes: it tends to establish a friendly relationship on the basis of which it is possible to discuss more tender points, and it also gives a good deal of information about the personality of the child. Children, except the most sullen, like to talk about their interests, and younger children will usually become so interested that they forget about the special situation in which they are placed.

This is partially true of older children but they, particularly when in serious difficulty, have in the back of their minds all through these pleasant preliminaries, the suspicion that these are a disarming preliminary for something unpleasant to follow. With such children it frequently is better to begin with the problem at hand and fill in other facts after that has been fairly well disposed of. The psychiatrist can ask the child quite directly how he happens to be at the clinic and with this can get into a prompt discussion of his difficulties. This can be done if the psychiatrist is extremely careful never to permit his questions to sound as if they were even veiled criticisms.

Many techniques have been elaborated to give the child an opportunity to express himself spontaneously. These vary with the child and with the psychiatrist. Some are rather elaborately formalized while others are loose and empirical. Mention has already been made of the psychiatrist observing spontaneous activity and yet himself remaining in the background, if possible unobserved. In the child guidance clinic this cannot be done as readily as in less formal situations. Children at play with one another sometimes give surprisingly frank expressions of their attitudes toward adults and adult situations if they think no one is about to hear them.

A group of boys in a school in which the teachers pride themselves on the close understanding between themselves and their pupils were observed playing a game in which each tried to introduce false statements without being "called" by his playmates. If the majority agreed it was a lie, he was pummelled by the others. When one of them observed: "All teachers should be sent to the moon," no one made a move toward him.

Young children also in their fanciful play at times give expression to hidden wishes. A five-year-old child once asked



his mother to cut out some paper dolls. There were to be four, a father and a mother and two boys. The larger of the two boys he named for himself and the smaller for his older brother. He said that this brother was a very little boy and had to go to bed at seven o'clock. It takes very little ingenuity to suspect that this youngster was jealous of the privileges of his older brother.

In lieu of spontaneous play activity, many psychiatrists, particularly in dealing with young children, have play equipment in the office and offer this to the children. Plastic materials are found to be quite suitable for this, as the child frequently will make representations of people important to him and discuss them as he does so. Dolls, which the child can use for re-enacting family scenes, will frequently give a child an opportunity to express attitudes toward his own home which would not come out easily otherwise. A doll which can be disjointed and therefore gives the child an opportunity to express particularly his aggressive attitudes toward people about him has been used effectively at times. Somewhat akin to affording the child the use of plastic material is to offer him pencil and paper and encourage him to draw something and then to discuss what he has drawn. A transition between play of this sort and the more formal verbal discussion of his attitudes by the child is found in encouraging the child to indulge in fantasies and story telling. A naïve child will sometimes reveal many of his wishes, hopes, and frustrations in such fantasies. Occasionally an older child with literary ambitions may be induced to bring in some of his writings or to write especially for the psychiatrist and thus reveal some of his inner longings and disappointments.

With older children, on the other hand, and in the case of some psychiatrists even with younger children, the usual contact with the child is quite frankly an interview. In order



to get as free an expression as possible in this way of the child's real attitudes, the psychiatrist needs to observe certain precautions. He must remain neutral in points of controversy between the child and his parents and on ethical problems. If he shows clearly that he disapproves of the child and favors the parents, the child will become suspicious and withdraw. On the other hand, if he appears to take the child's side the child will make every endeavor to present the picture in the most favorable light in order to win more approbation. If he remains benevolently and interestedly neutral, there is greater opportunity for the child to express himself genuinely. The psychiatrist also must learn to ask questions in a way which does not imply the answer. This is very difficult, particularly in dealing with children, as almost all children have encountered a good many adults who put questions to them which are really veiled commands. Some children seem quite unable to conceive of an adult who could ask any but rhetorical questions. It sometimes even becomes necessary for the psychiatrist to point out that he is genuinely interested in the answer to the question and is not simply trying to tell the patient something. When this once becomes clear to the child it is frequently a startling experience. It is delightful to find an adult who really wants to know the things that matter to him and the youngster becomes eager to tell all that he can about himself.

Occasionally the psychiatrist may take a position which apparently is not exactly neutral. The child is so prone to give conventional replies to questions and responses which he feels will meet with adult approval that it is sometimes effective in getting a genuine expression of attitude to show surprise when a conventional reply is given. For example, if the child says that he likes school, as he is very apt to do, the psychiatrist can ask him: "Why in the

world?" or "Why are you so different from many other children?" or something of the sort.

Children often have great difficulty in expressing their feelings in words. They find it easier to express them in other ways. Therefore, it frequently becomes necessary for the psychiatrist to put into the words the feelings which he is rather confident that the child has, asking him if he doesn't feel this way. He may, for example, say: "But I suppose sometimes you feel that your mother isn't quite fair to you. Most children do anyway." This is particularly true if these feelings are those which the child has attempted to conceal from adults, and, if the psychiatrist can so express them that no blame is implied, this can go far to increase the confidence of the child in the doctor.

It should be borne in mind that the psychiatrist is in danger of misleading himself when he puts his own words into the child's mouth. Such techniques are to be used with caution and only in so far as they aid in encouraging a spontaneous flow of attitudes and feelings.

It is the psychiatrist's aim to discover not only those motives and feelings which the child himself recognizes but also those which are hidden from him. The older the child the more deeply hidden these unrecognized motives are. With a young child the psychiatrist frequently needs only to convince the child that it is not necessary to conceal feelings from him as it may have been from other adults in order to get a picture clear enough to serve as a basis for a program of treatment. The older the child grows the more complete these concealments of motives become until at length they are often hidden almost as completely from the youth as from those about him. Even after the psychiatrist has succeeded in thoroughly winning the confidence of such a child or even when the child from the first comes eagerly to the clinic in order to get help, the task of discovering

what is really at the core of the child's behavior remains a difficult one. All the information gathered by the methods discussed hitherto will furnish clues and hints which in the light of experience with other patients may go far to give the psychiatrist an understanding of the child which he himself does not possess. But in addition there are two methods of investigation which are of particular value in disclosing the things which the child hides from himself. The first of these is a study of his dreams. Dreams tend to be more nearly an expression of the varied wishes and purposes of the dreamer than waking speech or action, and when studied by an experienced person can be very valuable, particularly in conjunction with the second method, free association. The tendency on the part of some individuals with a superficial smattering of psychiatric conceptions to be ready with pat interpretations of an isolated dream has done much to discredit this method in the eyes of the general public. There have even been attempts to prepare lexicons of dream symbols. This is a foolish performance, since the dream is a highly individual matter and the material that goes into it is determined to a large degree by the individual's past experiences. It is true that certain symbols tend to recur in dreams of many people, but these are few and general. The dream may unlock the door to the hidden motives, but the real exploration of these must be conducted through free association.

In free association the patient is encouraged to follow his thoughts no matter where they lead him and to talk about them as they occur. He is urged to give up his habit of criticizing and arranging his thoughts before speaking them and instead to give them just as they come, without reservation, no matter how embarrassing, silly, or reprehensible they may appear to him. This is a very difficult thing to do and it is only after a good deal of experience

that the patient achieves even an approximation of the goal. He can do it only as he learns to feel that the psychiatrist is genuinely not censorious. The psychiatrist may help a person to acquire this capacity in one of two ways. He may at the beginning of his work with the patient explain the method and its purpose and request him to make an effort to say everything that comes into his mind just as it comes. This, of course, is applicable only when the patient comes to the psychiatrist with a genuine wish to be helped. In other cases the psychiatrist by a judicious use of questions and careful avoidance of any implications can gradually win the patient to a more and more spontaneous revelation of his mental processes until he talks without reservations about things which he has hitherto hidden even from himself.

Two uses can be made of the information about the patient which the psychiatrist acquires in the course of his study. It may be a part of the knowledge through which the psychiatrist reaches that understanding of the child which he seeks in order to be able to plan a life situation most nearly in keeping with the child's needs. On the other hand, with adults frequently the goal in a psychiatric study is simply self knowledge by the patient, and the knowledge which the psychiatrist gains during the process is really only an incidental product. With many adults the obstructions to a satisfactory adjustment are found almost wholly within the individual and if these are removed he can be trusted to make his own life arrangements. This is largely true with some adolescents also, but the younger the child the more dependent he is on the decisions of those about him and the more important becomes the first use of the information gained by the psychiatrist.

In a child guidance clinic it is unusual not to make an effort to modify the situation in which the child finds him-



self, though in a good many cases the effort is also made to give the youngster a better understanding of his own attitudes.

Although the basic principles of the psychiatric examination are simple and common to all relationships between people, it should not be considered that the techniques are easy nor that they are free from danger. Quite the reverse is the case. The very fact that we infer the motives of others from a knowledge of our own attitudes makes us all liable to the error of seeing ourselves in others even though the resemblance is very remote. A psychiatrist calls these tendencies projection and identification. The person who identifies his own difficulties with those of another is likely not only to misinterpret the situation but to believe that a solution which he has found is applicable in this case as well. We see this in a very exaggerated form in all sorts of fanatics who are advocating their own particular mode of life as necessary for everyone. Workers in child guidance clinics see it almost as clearly, but not as gaudily colored, in many well-meaning persons who are really meddlers in other people's lives. Such people are not unlike the man who discovered that he had been talking prose all his life and assumed that in consequence he did it well. Their intellectual one-sidedness is complicated also by the fact that the person who has found a solution to life's problems which is fairly satisfactory to himself is apt to be in emotional need of providing himself with further assurance of its validity and seeks this unconsciously in forcing his solution on other people. In the course of his training the psychiatrist makes an earnest effort to correct both of these tendencies. He sees a great many people who are meeting life in a great many different ways which prove to be satisfactory to them although they are very different from his own. The truth is driven home to him that "there are nine and sixty



ways of constructing tribal lays and every single one of them is right." And he also examines his own satisfactions and solutions so thoroughly that he knows what is valid for him no matter what may be true of other people's experiences. He gets rid of the necessity for winning converts. The degree to which this is achieved in different psychiatrists varies, of course, and it is never complete. The thing to be stressed is that long and arduous training is necessary to achieve a degree of detachment and objectivity which will enable the psychiatrist to perform his task. Any person who rushes into a situation and attempts, without this training, to do what the psychiatrist does is very likely to do a tremendous amount of harm and very little good.

It should also be very emphatically stated that it is not an innocuous affair to encourage another person to disclose himself. That "confession is good for the soul" is only a half truth. Confession has a powerful influence upon the soul, but, unless the listener handles the self-revelation with extreme adroitness, the influence may be powerful for ill rather than for good. A discussion of inner attitudes may suddenly destroy a defense against a deep-lying anxiety which has stood strong for years. Often in the course of psychiatric treatment this is a step toward recovery but for the time being the patient appears worse. A psychiatrist aware of the total significance of things which are happening is not disturbed at such temporary exacerbations of symptoms, although he frequently takes precautions to prevent the patient from too rapidly throwing his life's pattern into the scrap-heap. The amateur who attempts to repeat the work of the psychiatrist is apt in one or two interviews to discover to his panic that his client's life structure is coming down in dust about him and to communicate his panic to the client. A psychiatrist who rather frequently is called upon to discuss with teachers and organized group workers

the psychiatric implications of their work is wont to say by way of warning: "Personality is dynamite, and it is an extremely uncomfortable experience to find a personality suddenly exploding right in your hands." The principle underlying an exploratory operation is a very simple one. One simply opens the cavity to be explored and looks and feels. But only a man who has had very adequate training in performing such an operation can be trusted to do it safely. The same thing is equally true of an exploration of the deeper levels of the personality.

No specific mention has been made of psychoanalysis in this discussion for two reasons. First, this chapter has dealt with the diagnostic examination, and psychoanalysis is in large part a treatment method. Second, a psychoanalysis requires a long time and much more frequent interviews than are usually possible in the child guidance clinic. To a fairly large portion of the lay public, psychoanalysis is synonymous with the psychiatric examination. Perhaps the analogy of the various laboratory analyses of the medical clinic explains this popular misuse of the term. Often a mother tells the social worker that her child was "psychoanalyzed" at another clinic or says to the psychiatrist: "I believe you're psychoanalyzing me instead of my child." The parent or child has no more been psychoanalyzed than the child who was weighed and measured at a public school clinic can be said to have undergone in the process an operation for removal of his appendix.

Formerly problems in young children were dealt with largely through attempts at treating the parental attitudes. The mothers' or fathers' disturbed views and feelings were taken as the focus of treatment or, if treatment of the parents and home situation did not seem feasible, foster home placement was contemplated.

In recent years there has been an increasing recognition

of the fact that many children's problems are the result of events in their emotional development, the effects of which cannot be readily modified by changes in their surroundings or in their parents. The problems of certain children tend to persist despite environmental manipulation.

It has been found possible to treat such children directly by modification of the psychotherapeutic approach made to adults. For this purpose a play therapy room is set up in the clinic which is distinguished from the ordinary consulting room by having a rather informal arrangement and by being stocked with various play objects such as dolls, automobiles, airplanes, sand box, a sink, a blackboard, drawing materials, plasticene, paints, lead soldiers, construction tools, and sewing materials. The child spends a period of an hour in this room with the therapist at weekly or bi-weekly intervals. During the period in the playroom the young patient is given complete freedom in the use of the available materials. By means of play the child expresses many of the things for which an adult uses words, that is, he tends to act out attitudes and feelings which the adult directly or indirectly expresses verbally. The therapist does not direct or limit the child's activity, since it is essential that he have opportunity to express freely both his constructive and destructive impulses. The therapist at the child's direction may assume various rôles such as mother, father, teacher, friend. The opportunity which the child thus has for freely expressing himself serves to reveal to the therapist the emotional problems involved, while at the same time it allows the discharge of emotional tensions related to these problems. In the course of this process a relationship develops between the child and the therapist through which, as in the case of adults undergoing psychiatric treatment, the child is able to express the conflicts over his life relationships.

When crucial emotions are present during the play, the

therapist may be able to explain to the child the connection between these emotions and the content of his play as it reflects his life experience. Where explanations are not possible or seem inadvisable, the mere fact of the therapist's tacit, friendly understanding encourages the child to work through spontaneously to some degree the conflicts that have produced the symptoms and necessitated treatment.

## Chapter X

### SYNTHESIS AND PROGRAM OF THERAPY

IN the preceding chapters frequent mention has been made of the futility of attempting to interpret all peculiarities of behavior from one viewpoint only, whether that be the child's physical condition, his intellectual equipment, his emotional make-up, or the situation in which he is placed. In the historical development of our understanding of the causes of behavior disorders in children an attempt has repeatedly been made to find one single cause at the root of every trouble. Members of the lay public have carried this tendency to the greatest extremes. In some communities it is widely assumed that any instance of unusually undesirable behavior must be due to a blow on the head sustained in childhood. Another example of this tendency to attribute all types of undesirable behavior to one single cause is seen in the confusion connected with the meaning of the word moron. This term is a psychological one and refers to definite retardation in mental development, but some years ago there developed a widespread popular misconception that all rapists were mental defectives, with the result that in much of the lay press "moron" has become synonymous with "rapist." The tendency to believe in a single cause of all behavior disorders is found in various quasi-scientific writers who attempt popular interpretations of the work in the various fields of personality study. Even the actual workers in these fields have not been free from this tendency. The physician, the social worker, the educator, the psychologist, the group worker, and the psychiatrist, each working independently,



as he did in the early days, found himself dealing with behavior problems and each was able to uncover pertinent facts which in some instances gave a fairly adequate explanation of the problem he was dealing with. Each quite naturally tended at first to push his particular interpretation to its very limit. Soon, however, it was discovered that in many instances other factors which the specialized worker was not trained to handle effectively also entered into the final picture. By the time this realization became clearly conscious in any large group of workers, each of the disciplines had developed techniques of diagnosis and treatment and standards which called for such specialization and prolonged training that it has seldom been feasible for one person to become proficient in more than one. Yet, if any child is to be thoroughly understood he must be studied from various viewpoints. The child guidance clinic, where specialists trained in each of these approaches study the child, is an attempt to answer this need.

It is not enough, however, that these separate studies be made. Although the viewpoint and methods of each of the workers are distinct, the object of study is decidedly a unified whole. The child himself cannot remain a living child and be divided into a body, a reflection of a social situation, a bundle of recreational activities, a level of intelligence, and a set of emotional attitudes. He is first and always a child. What he does with his body affects what he does with his mind. What the social situation does to him has a bearing on his emotional make-up, and his deep-lying emotional patterns decidedly affect the sort of recreational activities he enters into. Always there is interplay, and it is only for convenience that we make the arbitrary divisions in our study. It is essential that all who deal with the child see him as completely as possible from all available viewpoints. In the child guidance clinic this is achieved through

staff conferences. At these each examiner reports his findings and interpretations and engages in an attempt through free discussion to develop as fully as possible any understanding which he can give of the whole and living youngster.

In such a staff conference interpretations and recommendations are tentative until all findings have been reported, since again and again a recommendation which is perfectly valid from a limited viewpoint is seen to be incongruous with the total picture. For example, the physical examination may indicate that a boy needs glasses if he is to enjoy the most efficient possible vision. On the other hand, the psychiatrist may find him to be a boy who is having considerable difficulty in social contacts already, while the social study may show that he lives in a neighborhood in which the wearing of glasses is a very decided social handicap. When confronted with such problems, the staff members, together, attempt to weigh the handicap for any visual defect against the damage to the social adjustment of the boy, and if the latter danger seems the greater a recommendation of glasses is postponed. Again, a child may have a slightly disabled heart. If an examiner is more interested in the heart than in the child he will feel that the entire régime of the youngster should be directed toward protecting the heart muscle from undue strain. This may, however, if done injudiciously, result in chronic invalidism of a psychoneurotic sort and the person who is first of all interested in the child may feel that some risk to the heart itself must be accepted for the sake of the child's personality. On the other hand, the recreational worker may feel that a particular play program is very desirable for the child, but the physical examiner may have discovered some condition which makes such a program completely out of the question. In the light of this finding the recreational worker, with the rest of the staff, will attempt to find some modified program which

will as nearly as possible meet the child's play needs. Again the psychological and psychiatric recommendations may at times have to be weighed against each other. The psychologist may find that the child is intellectually capable of doing work in school considerably beyond his actual placement. If capacity to do the work were the only consideration there would be no question about recommending a promotion. However, the child's emotional and social development may be very much below that of his mental age and it then becomes necessary to weigh the advantages in giving him school work actually challenging to him against the disadvantages of putting such a child in a group where he will not find ready acceptance. It would be possible to multiply indefinitely such examples of the necessity of balancing one need against the other, keeping always in mind that it is the child himself and not his disorders that is our real concern.

Members of the staff conference, therefore, in a free and informal discussion attempt to arrive at a penetrating and at the same time well-rounded picture of the child and his needs and to outline a tentative method of meeting these needs. Some of these methods will be discussed later in the section on therapy. Certain problems are so common and show such little relative variation that it is possible to give a fairly concrete outline of methods of handling them. Other problems are so unique that methods of treatment have to be extemporized and there are all variations between these two extremes.

The resources are as varied as the problem. The most obvious, perhaps, but not the most frequently employed are the various treatment facilities in the clinic itself. In outlining a program of treatment, then, the decision must be made as to whether or not direct therapy with the child

will be undertaken. This may be done in any one of the departments.

A resource in the community which must occasionally be utilized is the machinery of the law. A fairly large fraction of the cases in most clinics are referred by the juvenile court. In a large proportion of these cases the rôle of the clinic in treatment is to advise the court what to do. Occasionally, also, a child may have such a vicious or incompetent guardian that the law must be invoked to remove him from this noxious influence.

A third resource is the home. In determining what can be done for the child in the home one has to consider a great many things, including the income of the family, the place of residence, and the abilities and emotional attitudes of various members. At times direct advice about change in the handling of the child will seem to be adequate to meet his difficulty. Frequently emotional attitudes of one or both parents may be such that they cannot follow any advice which might be given, and in these cases particularly the staff will suggest that some sort of psychotherapeutic influence be exerted on the parents. It should be made clear, however, that there is no sharp dividing line between psychotherapy and the giving of advice. Good advice is never of value unless it is followed, and the will as well as the understanding of the parent or other persons dealing with the child must be engaged if the child's problems are to be met.

A fourth resource for helping the child to get along better is the school, and various recommendations for modifying a school program are frequently made. Wrong placement in view of the child's mental ability may be discovered and a change recommended. An interpretation to the teacher of the motivations back of a child's undesirable behavior may help her to understand that there are better ways of



handling him. Direct suggestions for more suitable means of managing behavior difficulties may be of value. Frequently, if the curriculum is modified or the emphasis changed, it will meet the child's need more adequately. And at times the teacher herself may be brought to take a changed attitude toward the youngster and so very considerably benefit him. Sometimes the attempt of the teacher to understand the reasons for one child's misbehavior may result in a decided change in her attitude toward the whole school problem, enabling her to meet behavior difficulties in other children much more effectively than she has previously. The study of a child and the attempt to understand him may in itself be a psychotherapeutic procedure for a teacher.

Another resource for meeting the child's needs is the professional case working agency which nearly always continues some degree of active supervision of the case. The function of the child guidance clinic in such an instance is quite largely the interpretation of the child and his behavior to the agency which is primarily concerned in dealing with him. Special recommendations for meeting specific needs may be given. When the child has been referred by an agency it is very helpful to have representatives from this agency present at the staff conference. In the course of a spontaneous discussion workers who have dealt with the family will frequently mention details or give shades of emphasis which throw light on the problem in a way in which a formal written report cannot do. Also their knowledge of the resources of their own organization will enable the staff to make recommendations, consistent with what is actually possible to undertake. Furthermore, in such a face to face discussion subtleties in the recommendations come out which are lost in a written report.

Another resource is found in the organized recreational programs of the community. The child's play needs are



occasionally met by the direct activity of a clinic worker assigned to this particular problem, but more frequently the child is introduced to some play activity in charge of a trained recreational worker. There is need for much closer understanding than at present exists between the group worker and the case worker. In recent years there has been a growing awareness on both sides that the group worker could learn from the case worker a better understanding of the meaning to the individual child of his relationship to the group and that, if the case worker is to prescribe group treatment at all effectively, she must know a great deal more than she does at present about the difficulties and the possibilities of group supervision.

Another type of resource in handling the adjustment problems of the child is placement outside the home. At times the child and the situation in which he finds himself may both be so abnormal that it seems impossible to hope that he can possibly make a satisfactory adjustment unless he is placed, at least temporarily, in a situation more suitable for him. Such a separation may give an opportunity to treat either the child or the original environment, or both, in such a way that ultimately he may be returned to it. At other times the environment to which he would have to return may be so hopelessly unfavorable that a permanent new placement may be necessary. And at times the child is so extremely abnormal that a special permanent environment must be arranged for him. Foster home placement, of course, is often called for simply because there is not any other home for the child, but frequently also because the natural home of the child is so inadequate in one way or another that a substitute must be found if the youngster is to develop wholesomely. Institutional placement is still too generally looked upon as a last resort, a method by which custodial care is given to the child who is hopelessly in-

corrigible, hopelessly feeble-minded or hopelessly lacking in initiative and promise. This is an unfortunate view, as many children are seen in a child guidance clinic who are sufficiently abnormal to make the task of fitting them into a family practically insurmountable and yet who conceivably might benefit immensely and ultimately be returned to the community as fairly normal citizens if they could be given treatment in a therapeutic institution. Institutions of the right kind are beginning to appear in this country, but the facilities still lag far behind the need.

Before we go on to a more specific discussion of various methods of treatment we would emphasize, however, the fact that the interpretation of the child and the outline of treatment which is made at the first staff conference is always a tentative one and subject to constant revision as treatment progresses. Just as diagnosis cannot be separated from treatment and treatment begins with the first contact of the interested adult with the clinic, so treatment cannot be separated from diagnosis and diagnosis continues to be sharpened as long as the child's contact with the clinic continues.

## OUTLINE OF PSYCHOTHERAPY AND OTHER AIDS IN ADJUSTMENT

The following is a compact tabulation of the various ways, devices, and means used for treatment in child guidance clinics. The reader will appreciate that it is difficult to choose satisfactory terms to describe what one attempts to do with or for a child and it is difficult to arrange these into families or logical groups.

- I. *Direct aid through the psychiatric interview* (Various procedures which may be used in the direct, conversational contacts with the child. Some have very limited

applicability. Some are rather superficial, yet may be effective in certain cases.)

- A. *Devices depending upon authority* (These are obvious, topical, remedial devices, applicable chiefly in superficially grounded problems. They gain their value through rapport; the confidence which the patient places in the therapist; some degree of identification, authority, faith.)
  - 1. Advice
  - 2. Persuasion
  - 3. Direction
  - 4. Approval of certain conduct
  - 5. Disapproval of certain conduct
- B. *Devices depending upon approval* (These measures, applicable in relatively superficial and symptomatic problems or where some subconscious motivation, some minor conflicts are found, gain their value through the confidence which the patient places in the therapist, identification, emotional consonance, or suggestibility.)
  - 1. Demonstration of confidence in the child's ability
  - 2. Demonstration of understanding and sympathy
  - 3. Use of rewards
  - 4. Use of praise
  - 5. Encouragement
- C. *Devices depending upon the patient's use of intelligence to solve his problems* (These are applicable chiefly where the patient can look upon things objectively and where problems may be solved by conscious control.)
  - 1. Direct reasoning
  - 2. Use of analogy
  - 3. Presentation of material for reflection
- D. *Device depending upon authority at a deeper level than "A"* (It is applicable to problems in which there can be no dependence upon conscious recognition. Its value is limited, since it does not, of itself, solve conflicts, but merely permits re-

moval of some symptoms or permits some transient direction of the patient.)

1. Suggestion. (This varies from mild measures indistinguishable from advice or encouragement to suggestion under hypnosis.)

E. *Procedure combining intellectual and emotional approaches* (This is more generally applicable than any of the above and can be used on problems which are rather deeply grounded.)

1. Interpretation of the individual to himself, and of his situation, parents, etc., to him. (The patient must be ready both in his thinking and feeling. Interpretation should follow directly from known facts, merely placing the facts in a clearer relationship.)

F. *Process concerned with emotions at a deeper level than "A" and "B"* (This is not a technique but a process which may occur if the therapist provides favorable conditions.)

1. Encouragement of catharsis. (This process, an unfolding of the conflicts through a conversation, as little directed by the therapist as possible, is useful in problems involving active conflict, not too deeply grounded. It permits emotional release and redirection by the patient himself. It can often be combined with interpretation and often takes on some abreactive value, especially if it is intensive and prolonged.)

G. *Process of releasing the patient from emotional conflicts at a relatively deep level* (The provision by the therapist of a situation favorable for an expression or externalization of deep conflicts and hidden emotional reactions. The reactions may be focused on the therapist or on something such as a doll, which is used with young children. This focusing occurs in relation to material which is being revealed by the patient and by reason of the identifications the patient makes between the present object and the original objects of these

feelings. The significant characteristic is that of active release of repressed emotions. This process is of value in cases of deep conflict. It may be an associated phenomenon in catharsis. The abreactive phenomenon ordinarily involves the expenditure of much time. It may not be a feasible means of treatment with many cases in a very busy clinic. Play technique may be applicable in cases not open to the cathartic method [as in very young children]. Like catharsis, abreaction is not a technique but a process. The therapist can only provide conditions favorable for its occurrence. The abreactive phenomenon is a means of releasing the patient from emotional conflicts at a relatively deep level.)

1. Encouragement of abreaction through
  - a. catharsis
  - b. transference
  - c. play technique

II. *Other ways of helping the child toward a better adjustment* (The psychiatrist may suggest or initiate these steps and he may take the major rôle in getting them accomplished. Or the suggestions and impetus may come from others of the examining unit and the practical procedures may be undertaken by them. Often workers or other agencies will undertake these suggested steps.)

A. *Opportunities and aids, not greatly involving the interpersonal relationships in the adjustment of the child*

1. Health measures: diet, operations
2. Recreational opportunities, play equipment
3. Opportunity for developing certain aptitudes
4. Aid in getting over some handicap, as difficulty in learning to read
5. Opportunity for effective functioning within his limitations, as special school placement for the crippled child



6. Proper grade placement or other changes at school
  7. New placement, foster home or institution in cases when "anything would be better than his own home"
- B. *Aids involving interpersonal relationships in the adjustment of the child*
1. Arranging for someone outside of the family to take special interest in the child. This may also apply in some instances to the items listed under II A; for example, certain group contacts, a certain foster home, a certain tutor; any of these might be selected because they would supply individual, special interest, etc.
  2. Arranging for group contacts
  3. Interpretation of the child and his needs to key persons in his environment. These may be his parents, certain friends, his teacher, etc.
  4. Direct influence upon key persons in his environment along some of the lines enumerated under I in order to provide a more fitting environment for the child. In some instances, the parent will be given psychotherapeutic treatment. Assistance to key persons in his environment, providing for their general happiness, better adjustment, etc., which will be reflected in the child



PART III

THERAPY: ILLUSTRATIVE CASES



## Chapter XI

### PROBLEMS ARISING FROM INTERFERENCE WITH THE CHILD'S OPPORTUNITY TO GROW: CASE STUDIES

#### Ruth J.

**R**UTH J., a girl of three years and eight months, was brought to the clinic by her mother because of retarded development and behavior difficulties. Ruth had temper tantrums, particularly when ignored. She showed considerable tendency to do the opposite of her mother's wishes. This tendency had recently become much more pronounced. Her screaming had been troublesome for six months, but it had become very much worse during the past three weeks.

At the Institute Ruth screamed almost continually and in a barbarous fashion. The screaming seemed unemotional, almost mechanical, but was extremely vigorous.

Because of this type of behavior it was difficult for the psychologist to obtain an intelligence rating which she considered accurate, although Ruth did cooperate in some of the tests. The results of these, coupled with other observations, suggested that it was safe to assume that her mental growth would probably proceed more slowly than that of the average child.

In the interview with the mother, Mrs. J., the psychiatrist learned that at about the time the screaming became decidedly worse, Ruth's negativism increased. About three weeks prior to the Institute examination the mother's older sister visited in the home and stayed for two weeks. This



aunt took the responsibility of advising the mother how to manage Ruth, and, furthermore, she herself took an active hand in disciplining the child. She slapped Ruth's hands sometimes and scolded her much and frequently. The screaming became worse during this period. A week before Ruth came to the Institute the sister left, but the mother reported that there had been no change in the child's behavior. During these three weeks spitting, a habit which had formerly been present, but which had disappeared, was re-established.

A year prior to the examination Mrs. J. consulted her pediatrician because the child was retarded in her speech development. He advised her to set aside a definite time each day to put Ruth on a chair in front of her and to teach her to speak by having her watch her mother's lips. The mother attempted this for fifteen minutes a day for two weeks, but as the response of the child was unmistakably negativistic she discontinued this practice.

It was also distressing to the mother that Ruth did not tell her when she needed to go to the toilet. It was necessary for the mother to take the responsibility for watching her and for putting her on the seat and this provoked a negativistic reaction and resistance on Ruth's part. Furthermore, Mrs. J. was much perturbed over the child's fingering her genital organs. She thought that she could prevent this in the daytime by diverting her attention. Because she was afraid Ruth would engage in this practice before going to sleep she adopted the habit of lying down with her and holding her hands until she was asleep.

The psychiatrist made suggestions to the mother in a more or less tentative fashion. He suggested that the most important problem was that of overcoming the child's antagonistic attitude and the negative suggestibility associated with it. In this connection he advised ignoring many unde-

sirable details of behavior, but further suggested that when it was necessary to make an issue over something the adult should be firm, but unemotional. He counseled avoidance of all unnecessary pressure on the child for the present and advised continuance of the program of taking responsibility for the child's toilet habits in a fashion calculated to provoke a minimum of antagonism on her part.

Mrs. J. desired specific advice about Ruth's playing with other children because, as she stated, Ruth did not get along very well with them. The psychiatrist suggested that a policy be determined from a trial of its results. So long as the disagreements with other children were intermittent and were gotten over in some way it would be desirable to have Ruth play with children not too much mentally in advance of her. However, when Ruth seemed completely unable to make a social adjustment it would probably be wiser to remove her from the situation. He further indicated that Ruth's difficulties in play adjustment were the usual ones experienced by children at this age level.

The mother asked about the child's future development and was advised that probably Ruth would be slow in her mental development and would probably find it necessary to repeat some grades in school. It was suggested that in planning for her future it would be wise to think in more simple terms than the parents otherwise would choose. This opinion distressed Mrs. J., but she seemed to accept it.

A month later the mother brought Ruth back to the Institute as requested. In contrast with her previous behavior the child played quietly in the playroom. She seemed a little self-conscious about playing with the other children who were there, but became involved in no difficulties with them. She greeted the examiner in a friendly way and acted like a well-trained child of about two and a half.

Mrs. J. reported that Ruth had shown a marked improve-

ment during the month. The first indications of this became apparent about a week after the Institute examination and there had been progressive improvement since then. The screaming and the masturbation had disappeared. Ruth was more affectionate and had added a few more words to her vocabulary. She exhibited more interest in other children and played rather happily with them. The mother mentioned that when another young child came to the home Ruth would take him by the hand and lead him to her toys. She also reported that the child seemed much happier than she had a month before.

Ruth had not learned to tell her mother when she needed to go to the toilet, but she no longer resisted being placed there.

On one occasion the child had wandered off and was found an hour later by the police on the railroad tracks. Since then Mrs. J. had given her no opportunity to wander off.

Mrs. J. felt that Ruth was still somewhat more negativistic toward strangers than is the average child. She was doubtful as to how much more negativism was present in her attitude toward her parents than in the average child, but thought that perhaps there was a little. The mother was highly pleased by the improvement in Ruth's behavior and planned to continue the modified methods of handling the child which were apparently proving successful.

**Discussion.** A review of the case shows that Ruth's difficulties such as screaming, contrariness, and stubborn resistance to all suggestions were not the result of traits inherited from her father's family \* nor the result of deliberate disobedience. Rather they were symptoms of unwise, though doubtless well-intentioned, handling. Although in the case of Ruth there was evidence of some mental retardation, this was believed to have no direct influence upon her negativistic

\* The history was given by the mother.

behavior because negativism is found in children varying widely in intelligence. We have seen, in Chapter I, that the innate tendency to growth is present from the beginning of life and therefore opportunities for promoting that growth need to be present at all age levels if the individual is to develop to his full capacity. Too much interference with the unfolding of a child's personality and the achieving of independence produces resentment and the kind of negativism observed in Ruth. This resentment may occasion a parading of independence by the young child. To his mind the most spectacular and impressive way of asserting independence of a parent is to oppose the parent's requests. Here, the mother's respect for the child's own personality enabled her to accept the importance of modifying her handling of the child in the direction of eliminating unnecessary pressure and ignoring unimportant details of conduct. In this way Ruth was relieved of the experience of constant frustration and over-direction and became freer to respond acceptably to whatever assumption of responsibility it was still necessary for her mother to take. She became freer, too, to become, as it were, outgoing, and friendly toward other people, both adults and children. She no longer had to exert great energy to protect herself from invading directiveness and domination by others. The result was a happier, more affectionate child who could proceed from this time on to develop better social relations.

### Lorraine

With some children interference with their natural growth process through over-direction has different results, as in the case of Lorraine, who was referred to the clinic at the age of five years and nine months by her mother who was distressed because she considered Lorraine lazy, lacking in initiative, selfish, and absent-minded. The family was well-



to-do and Lorraine's care was divided between her mother and a nurse, both of whom were over-strict and used repressive measures to gain immediate and unquestioning obedience. Earlier efforts of the child to obtain some independence of action had been met with stern prohibitions. The mother felt that parents know much better than children what is good for them and in her attempt to teach unselfishness and subservience to the parental wishes had adopted the policy of consistently refusing any request originating with the child. The result was a child who lacked initiative in all fields. Since active rebellion had earlier brought only severe punishment, the child gradually developed an extremely passive attitude. She was indifferent and "selfish," dawdling over tasks which could have been accomplished in half the time. Obviously there was little or no incentive for her to do otherwise, since completion of a task never meant any opportunity to undertake anything of her own choosing. The psychological tests showed her to be a child of superior intelligence who conceivably would have been capable of high achievement, had she been encouraged to undertake new occupations joyously and to experience the satisfaction of accomplishment through self-initiated purposive activity.

It was felt by the clinic examiners that unless the handling of this child was greatly modified she would become passive and preoccupied to an unfortunate degree and later, perhaps at adolescence, she might break out in open and serious rebellion, doubtless with unhappy results to both herself and her family.

**Discussion.** The results of interference with the opportunity for growth of the developing personality are especially apparent in children of preschool age and in adolescents who are trying to relate themselves to a larger social world and its increased freedom. A rebellious attitude which has carried over from infancy to the "teen" ages may have become a



well-established pattern and therefore more difficult to eliminate. Consequently an approach from more than one angle may be required before any change can be effected. This is illustrated in the following case.

### Caroline G.

Caroline G. was an eighteen-year-old girl, the older of two children. The family lived in a small town some distance from Chicago where they owned their home and were well thought of in the community. In contrast to her brother, aged sixteen, who was serious minded, ambitious, and who conformed to the family pattern and selected his friends from among the "best people," Caroline was uninterested in school, resisted all attempts at control by her parents and showed little discrimination in her choice of friends. In fact, she seemed to prefer to associate with the "bad girls" of the town and was much talked about because of this. She had a marked interest in men, including some of bad repute. For these reasons and because her mother, Mrs. G., wished vocational advice for her daughter, Caroline was brought to the clinic. Caroline had left high school at the end of her third year and had come to Chicago to attend an art school for the summer. At the time of the examination she was insisting that she be allowed to remain in the city without her parents and to continue in art school during the coming winter.

The history disclosed that there was always considerable antagonism between brother and sister, that she had always hated school, had repeated several grades, and had exhibited indifference to her teachers. However, she had been regarded as a "sweet, lovable child" and the mother reported no difficulty with her until about the age of thirteen. At that time the family moved to another town and Caroline made friends with a girl whom the parents felt to be socially inferior, as

she was the daughter of a gas station attendant. Caroline's father was very proud of his ancestry and in his devotion to his daughter was much disturbed over her association with any one whom he felt to be inferior. The parents tried to break up this new friendship only to have Caroline insist on seeing her friend, resorting to subterfuge if necessary to carry out her wishes. After a time this friendship gave way to another, equally disfavored, which the mother again sought vainly to dissolve. She probably felt the "disgrace of inferior associates" less than did the father, but was the one responsible for the active steps taken to combat it.

Finally Caroline made friends with a charming girl, the daughter of a physician, and over this the mother was quite happy. Nearly two years later she learned through town gossip that Caroline had been initiated into various types of sex play by her latest friend and the latter's young brother. In spite of heroic efforts the family was unable to break up this friendship until they finally left town. In their new community Caroline again selected as companions two girls of whom her parents disapproved because of their reputations, and her interests now were chiefly in dates and petting. Her rebelliousness to her parents increased steadily and she lied to them almost constantly. She had frequent temper tantrums and much of her behavior was described as "willful disobedience." Some of it was quite bizarre and the mother was especially shocked by Caroline's interest in sex terms and vulgar phrases and her absorption in people of unsavory character. She protested that the girl was ruining her reputation and bewailed the fact that in her behavior Caroline never considered "a mother's feelings." The father considered the mother's methods too easy and demanded vigorous action to curb the daughter, but on the other hand he was almost lavish in the amount of money he gave her. This was

particularly true even in view of a definitely reduced family income.

The study at the Institute revealed a very slender, rather attractive-looking girl of superior intelligence whose energies were poorly directed. She was quite self-centered, much interested in her attractiveness to men, but showed no warm feeling for any one except some of her girl friends. She was dissatisfied with everything, even with her art work, although it was the one thing she had always wanted to do. Much of her behavior was felt to be rebellion against over-protective parents who were quite moralistic in their attitudes and overly interested in social position. It was decided that an opportunity for her to develop in her particular field, art, was important and that recognition here, together with a less restricted social environment, might make her problems less acute.

The director of the art school reported that Caroline had good ability and the parents were willing for her to continue there through the winter and live at a girls' club maintained under religious auspices. It was probably not so much recognition of the girl's need that prompted this decision, as sheer hopelessness, for the parents were at the end of their resources. The father expressed it well when he said to the psychiatrist that, although she ought to be at home, they would not know what to do with her if she were. She was completely out of hand.

It was felt by the Institute staff that Caroline needed some steering and some support in this new situation, but that it would have to be given skillfully and subtly so as not to arouse her antagonism further. She needed the experience of making her own decisions and accepting the consequences of them. But she could not be cut loose to sink or swim when her training had obviously never been the kind to foster a gradual development from the dependency of childhood to an

adult responsibility for herself. She craved independence but lacked the in-between experiences calculated to develop judgment.

With these points in mind a social worker was selected who, it was planned, would make friends with Caroline and give her some support without becoming authoritative. The worker was a young person herself, not too much older than Caroline, but with enough maturity to understand many of Caroline's difficulties. Her own interests were somewhat similar to those of the girl and she was acceptable to Caroline as a friend whom she could comfortably introduce to her other friends. The worker met Caroline for tea after school, they had dinner together occasionally at the girls' club where she lived, downtown, and at the worker's apartment, and Caroline came occasionally to the Institute for interviews. Throughout this time she was encouraged to discuss with the worker whatever interested her: her school work and plans for the future; her girl friends at the club; the various men she had known and liked, with reasons therefor; the parties she attended; and her relationships with her family and the people in her home town, where she returned to spend nearly every week-end at the parents' suggestion. While maintaining a non-criticizing attitude, the worker helped Caroline express and examine her confused feelings toward various people, to evaluate her own behavior and gradually to come to understand somewhat not only why she felt and acted as she did but also what lay back of her parents' attitudes. The worker suggested reading to Caroline which might be helpful to her. Together they discussed some of the personal implications of the ideas in this reading.

During this period Caroline's dissatisfaction with the school and with herself continued. She attended irregularly and finally changed to another school where the emphasis was chiefly on costume design. Her own interest in exotic



and bizarre effects in clothes continued. She dyed her hair and was delighted with the excitement this caused at the club. Her extravagance, of which the family had previously complained, continued even in the face of a somewhat diminished family income. After a time, however, she began to be concerned over finances and conceived the idea of doing part time work as a model in a dress shop in order to lessen her financial demands on the family as well as to get more spending money for herself. The worker pointed out the advantages and disadvantages of this, but left the decision to Caroline, who finally dropped the idea. In the spring, quite on her own initiative she obtained for herself a housework job as a mother's helper. She evidently hoped her father would continue to send the full amount of money for her board and she would thus have more to use for clothes, but this he declined to do, agreeing to send her half the usual amount. She made no objection to this plan and by this time she was quite able to see his point of view. The fact that her job would keep her at home every evening, taking care of the baby in the family and give her practically no chance to attend the frequent parties, which she had enjoyed, apparently disturbed her not at all.

Without doing any declaiming about it, she settled down to much more serious work at school, discontinued her frequent absences there and took on the added responsibilities of her job with credit to herself and satisfaction to her employer. The worker, acting as consultant and confidante, was impressed with Caroline's judgment of situations and her growing insight into her own behavior. It became apparent, too, that while Caroline had a flair for the unconventional, her behavior as seen from the larger perspective was much less bizarre than it had appeared to the family in their smaller community. When faced with the opportunities for somewhat more unconventional activities in Chicago than at



home, she evaluated these situations sensibly and patterned her behavior along wholly acceptable lines. These decisions were the result of her own thinking and judgment rather than of restrictive or coercive measures applied from without.

During the spring the mother came to Chicago and the worker had some opportunity to become better acquainted with her. She proved to be quite proud of her daughter's ingenuity and resourcefulness and admired the "spirit" she had shown. The mother disclosed a certain sympathy herself for behavior which deviated from the rigidly conservative mould in which she was forced to live, at the same time recognizing the practical necessity of conformity. The worker, utilizing this attitude, was able to interpret Caroline's behavior to her mother and in turn to bring to Caroline a fuller understanding of the mother's position and of her underlying hopes and aspirations for her daughter. In this and in previous contacts with the mother through letters, the worker's rôle was one of mediator and interpreter.

In June, Caroline returned to live with her family, thus carrying out a plan she had been considering for some time, namely, to live at home and to attend the college there and to take a business course through the summer which would later enable her to get work. She planned, also, to study sculpture with an artist in the town. Interestingly, the suggestion of the business course had originally come from her brother whom formerly she had heartily disliked. He, too, was planning to take the same course that summer.

In making and carrying out these plans, Caroline was able to proceed in a much more matter-of-fact way than had characterized her thinking and planning of a year before when she left home to study in Chicago. With much more clarity she could understand her situation. The insight she had gained increased her tolerance for her family and lessened her need to oppose them. The plan initiated by

herself met with the parents' hearty approval in contrast to their grudging consent of the year before.

If the family does not reassume repressive measures or insist upon planning and managing her life as before, but encourages the independent, responsible, growing-into-adulthood behavior which she is now manifesting, the prognosis for Caroline's ultimate adjustment is felt to be highly favorable.

### Jefferson L.

Jefferson L., a sixteen-year-old boy, was referred to the Institute by his mother because he had become "cynical, insolent, and totally irresponsible." He was rude and insolent especially to his teachers and his mother. Jefferson's mother had taken him to the family physician who had advised her to refer him to the Institute. Jefferson's reaction to the suggestion was, "I wish you would, mother. I don't know what is the matter with me. Sometimes I think I am half insane."

Jefferson's mother was proud of her descent from Southern aristocracy and of the status and success of a number of her relatives. "Nowhere is there a black sheep—a skeleton in the closet—and Jefferson must not go wrong either." She had had to take responsibility early in life and had become the dominant member of the household. Jefferson's father was a stable, kindly man, a metal worker, whose background and education were more limited than those of his wife.

Jefferson's family had been overtaken by a series of domestic calamities. During Jefferson's early life his father was a farmer and Jefferson acquired tuberculosis from the milk of an apparently healthy cow. During his illness the family was burned out one winter night and then lost on shipments of livestock as a result of a railroad strike. There was much other illness in the family during the following period which was marked by hardship including cramped living in a poorly

heated shack. Jefferson and a brother required sanitarium care several times.

When Jefferson returned to school after having been in the sanitarium fifteen months he was still sickly. He was picked out and called a "sissy" by the boys until he reached the eighth grade, when he had a fight over being called that name. Jefferson had an excellent voice and his mother arranged for singing lessons. He enjoyed singing but apparently this interest did not increase his acceptance of himself in a masculine rôle.

When a sophomore in high school, Jefferson was pleased at the prospect of participating in track, but the family physician noted findings at the periodic examination which led him to suspect a morbid condition of the heart and forbade participation in athletics. In the words of his mother, "Jefferson was crushed—'I am only a sissy,'—and our troubles began. From a lad of honor and truth he began to lie, to put things over, run around nights, became insolent, indifferent to his studies, a wise-cracker and a smart aleck."

The physical examination of Jefferson at the clinic revealed a visual defect. (Jefferson had worn glasses but had recently broken them.) No evidence of cardiac lesion or disorder was detected in this examination. It was suggested that the family physician be again consulted regarding his heart and the amount of athletic participation which might be permitted.

Jefferson's performance in a mental test indicated superior intelligence.

The psychiatrist described the boy as tall, slender, but fairly muscular, with rather attractive features. He had a smooth, polite manner, but gave some evidence of not welcoming the conversation he was going to have. As the interview progressed, however, he became quite frank and discoursed freely. He spoke of the fact that the boys formerly

called him a "sissy," but he could not see that his manner was at all "sissyish" now. The girls seemed to continue this view more than the boys, but even they were doing it less than formerly. The psychiatrist felt that the girls might be calling him "sissy" because of the restrictions which were placed upon him at home or perhaps because he showed mannerisms in the presence of his schoolmates which were not in evidence during the psychiatric interview. Jefferson said that his misbehavior in school was due to a desire to be funny and to win the approval of his classmates. Also he resented being ordered about by women teachers. He had now reached the point, however, where he was about ready to give up the rôle of classroom rebel and clown.

Speaking of his parents Jefferson said that between him and his father there was real understanding. He thought that his mother did not understand him at all.

The psychiatrist discussed with Jefferson the probable rôle that the challenge to his own virility had played in his rather unreasonable reactions to his women teachers and his mother.

With the mother the psychiatrist discussed the problems relating to transition from the status of a child to the status of an adult. He endeavored to explain how Jefferson's earlier sickly condition and reputation for being "sissyish" had given him a particularly strong drive to attain recognition as a thoroughly masculine person and how in his mind taking a man's position included not being under the orders of women. It was suggested that some agreement be struck with Jefferson regarding the matter of the hour at which he should come home in the evening (this had been a sensitive point) and the number of nights he could go out each week, subject to revision. It was particularly stressed that it would be desirable to talk everything over to reach an agreement, rather than to proceed to the direct imposition of restrictions. The

psychiatrist endeavored, in short, to interpret Jefferson's reactions to his mother and encouraged her, without completely "turning him loose," to give him some sense of his being accepted on an adult level.

Because the family lived at a distance from Chicago, repeated contacts with Jefferson were not feasible. A letter from the boy's mother after the Institute examination stated in part, "Jefferson finally had to give up both athletics and music, but he is president of the Student Body, stood 100 in a physics examination with an average of 98+ in physics for the semester. Has had parts in all plays and operetta. Is second highest average in senior class. Hoped to make the Navy, but is barred by his vision. What do you advise for a career?" His mother ascribed the improved adjustment largely to the aid given her and the boy in the single contact at the Institute. How much of the improvement should be so ascribed and how much is due to the spontaneous readjustments of growing up is problematical. It is not unlikely that he will have some further conflict with his dominating mother or with someone else to whom he may transfer some of the rebellion he has felt toward her. For the time being, except for the discussion of Jefferson's vocational adjustment, no further contact with the Institute appears necessary.



## Chapter XII

### PROBLEMS ARISING FROM FAILURE TO SUPPORT THE CHILD'S DEPENDENCY: CASE STUDIES

#### Robert

**R**OBERT, an eight-year-old child, in the third grade, was brought to the clinic by his anxious parents. They wished to have him examined because he had been excluded from school in the town near Chicago where they had lived for several years. He was a strong, healthy boy, well built and active. His manner was pleasant, apparently straightforward and frank, and he seemed to be at ease during the various examinations.

The school reported that Robert was untruthful, mean, sly, selfish, had no sense of social responsibility in the classroom and could not get along well with other children. His school work, particularly reading, was below average for his grade. The principal and teacher cited many examples of his undesirable behavior, among which the following are typical: when marching in line he pushed the whole line from the top of the stairs, making the children trip and fall; he stuck pins in the boy in front of him and suddenly tripped and kicked boys marching near him. In the classroom he walked around during the study period; he sang while the others were reading; he read aloud when they were having silent reading and did many other petty, annoying things that upset the classroom daily. All during the time he was behaving so poorly he looked innocent and kindly, smiled

in a friendly fashion at the teacher, and pretended to know nothing of what had happened. The teacher felt he was unreliable in every respect. Several complaints were made to the parents. When his mother came to visit the school, Robert behaved very well; he studied in the prescribed fashion and became a model of behavior.

The mother explained Bobby's conduct to the school by saying he was an individualist, a non-conformist, and was accustomed to "thinking in his own way." She later admitted to the school that she frequently whipped him at home when poor school reports came, but that "nothing seemed to do any good."

As Robert had been in this school only a short time, a report was requested from the school he had attended formerly. Although his mother said there had been no difficulty prior to his change in schools, the principal of the former school said that since kindergarten there had been records of undesirable behavior and that suspension from school was considered on two occasions. The principal had felt that he could handle Robert without bringing in the parents.

The parents denied similar behavior at home, stating that Robert got along well with the neighborhood children, had many friends, was generally obedient and reliable. However, they later admitted that he did many annoying things at home which exasperated his mother and kept her in an almost constant state of irritation and weariness.

The physical examination showed Robert to be of normal height and weight for his age and in good general physical condition.

The psychological examination revealed a mental age a few months in advance of his chronological age, putting him in the high average classification. He was properly placed in school for his mental age. Achievement tests indicated that his arithmetic was up to expectancy for third grade, but that

## Failure to Support Child's Dependency 181

his ability in reading and spelling were about 1A grade, a retardation of about one and one-half years below his arithmetical achievement and his mental age. A diagnostic reading test showed that he had a specific reading disability.\*

The psychiatrist believed that Robert's school difficulties would turn out to be closely allied to attitudes and tensions in the home. Because Robert had developed little sense of coöperation and acted directly according to his likes and dislikes, it seemed probable that he would have difficulty in fitting into the public school, with its over-crowded classes and emphasis on routine. His reading handicap apparently added to his feeling of insecurity in competition with the class. It appeared that treatment of Robert's problem would necessitate a revision of the parents' attitudes as well as special tutoring in reading and spelling for the boy.

There was tension in the family and it had evidently been growing over a period of years. The parents had known each other since childhood and grew up together until adolescence. The father then went away to boarding school and to college, spending only a short vacation at home each year. The mother remained at home and did not go to college. When the father returned to the neighborhood to live, he and the mother spent much time together and were soon married.

The father had been an unhappy, sulky child who long remembered any slights. His home life had been unhappy and he and his father could never agree. Boarding school meant to him an escape from an increasingly difficult home situation. The mother had been closely protected by her parents and enjoyed little experience outside of her own family group. The interests and activities of these parents were quite divergent, and the mother gave up all that did not fit in with those of the father, endeavoring to interest herself in such things as interested him. In this way it came

\* See Chapter VII, The Psychological Examination.

about that they went in for sports and games toward which the mother had no strong inclination except that which came from reflection of the father's enthusiasm.

Soon after marriage and about the time of Robert's conception, the father became ill and had to give up his work. He and his wife, of necessity, lived with relatives. The mother was troubled with nausea and was otherwise uncomfortable during the entire pregnancy, and when Robert was born he came into a family group which was ill prepared to love him because they did not really want him. Although the parents had planned to have children some day they had not wished one so soon after marriage and were unhappy at the prospect. The father was very anxious that the baby be a girl and was bitterly disappointed when Robert was born. He even refused to look at the baby for several days after its birth. Because of their precarious financial situation they could not afford a nursemaid or helper, so all of the mother's time was taken up with caring for the baby and this excluded her from any of her usual activities with the father.

When the father was able to return to work it was to a job with long hours. He came home tired at night and was irritated by the baby. Gradually he found recreation outside the home and spent several evenings each week playing cards with a group of men in the neighborhood. At times he would spend evenings and week-ends playing with Robert, who adored his father, but weeks would go by when he would be irritable and annoyed with the boy. The mother, tied down by her housework, had little recreation with the father and frankly stated she felt Robert was the cause of the gradually deepening estrangement from her husband. Her feeling toward Robert was ambivalent, including both resentment and affection, but in all choices he came second to her husband. As Robert grew older the father was accustomed to find his recreation away from the family. The

## Failure to Support Child's Dependency 183

mother became discouraged, tired, self-pitying. Both parents alternately showered attention on Robert and then were cold and irritable toward him. The mother thought it was the father's duty to take more interest in Robert and they argued over this and many other matters, mostly trivial. The father maintained that the mother's inconsistent discipline and constant nagging were the basis of the boy's trouble.

Robert was conscious of his parents' ambivalence toward him. He resented his mother's attitude in the home and her slump in morale. He was very fond of his father and regarded him as an ideal. After a period when he enjoyed his father's attention and companionship his behavior was noticeably improved.

**Discussion.** In Robert's history a rather clear picture is seen of the reactions of a child who feels that he is not loved or wanted. Deprived of the security and warmth of affection which every child seeks and needs, he apparently sought his parent's attention by behavior which they could not ignore as they had ignored his more acceptable behavior. By keeping their attention in whatever way he could, he did not need to recognize or acknowledge to himself the fear that they did not love him. Nevertheless, this fear, in a more subtle, unacknowledged way, was present and was probably the major factor in his misbehavior. While he was dependent on his parents for emotional support and a sense of security he was aware of and resented their being withheld from him. He was barred from the open expression of resentment toward his parents because that might alienate them further and jeopardize what small approval he did receive. These attitudes could find expression away from home and doubtless played a part in his misbehavior in school. There he could show toward his classmates and teachers some of the hostility which could not find expression at its source. Superimposed upon this state of affairs was a reading disability



which increased his feeling of inferiority and inadequacy at school by throwing him into competition with which he was unable to cope.

Behavior similar to Robert's is often seen in children whose histories reveal them to be unwanted and unloved by their parents. Frequently problems more serious than Robert's develop and many instances of irritability, destructiveness, lying, and stealing which come to the clinic grow out of a similar emotional deprivation.

This is not always the picture, however. Some rejected children find a challenge and a stimulus in the situation and, instead of showing their resentment in unacceptable behavior, conduct themselves in a socially approved fashion in order to win the love and affection they need. If this cannot be obtained from their own parents, they seek it from others who are able to respond with the emotional warmth they crave and who thus become substitute parents to them, the wished-for "good parents." This type of reaction often finds expression in the "goody-goody" behavior of some children who attempt to be models of behavior at all times, who need to feel themselves so good that others cannot find fault with them. This type of child is less often seen in the clinic because parents and others are less disturbed by this kind of behavior. However, such a child may be in as much need of guidance into healthy emotional reactions and attitudes as is the child like Robert who behaves in an unruly manner. Their emotional needs and deprivations have an equally strong influence on the manner of their ultimate personality development.

Treatment in Robert's case was undertaken both directly, through providing for some of his immediate tangible needs, and indirectly, through an attempt to help the parents see

## Failure to Support Child's Dependency 185

and accept, at least partially, the real problem. As private school was not financially possible, half-day sessions in public school were arranged for, supplemented by tutoring for the other half-day period, the latter in order that Robert might catch up in reading. When Robert returned to school it was to a new teacher, a young woman whom he liked. His behavior in school was still occasionally annoying but improved a great deal over what it had been. Even though his reading was poor, he was allowed to pass with his grade since he was showing some improvement from being tutored. The tutoring continued during the summer and when school reopened he was again excused from part of the afternoon period for reading lessons. His improvement in reading increased his sense of achievement and thus his feeling of security in school, and this probably contributed to his improved behavior.

During the summer Robert was sent to a camp for a short period and there he got along very well. The reports from camp indicated that after the first two or three days he accepted cheerfully the camp routine and entered eagerly into many types of activities. There was almost no behavior of the annoying attention-seeking type, and he made friends readily.

While these relatively direct steps were being taken to assist in Robert's more acceptable adjustment, consideration was given the parents' own attitudes and emotional problems. They were eager for outside help in arriving at an understanding of Robert's needs and that made them willing to discuss their own situation.

The treatment plan was not one imposed by the clinic but rather a coöperative effort between the case worker and the parents as they came to recognize and accept Robert's problems as a result of their own maladjustments. It was decided that the responsibility for the treatment program might well

be assumed by the social worker in this case, with frequent consultations with other staff members, particularly the psychiatrist. While both parents were problems in themselves because of emotional immaturity and maladjustment, the clinic's essential concern was the way in which they affected Robert's happiness and development. If these parents could be brought to recognize the serious import of their own problems on their child a long step toward Robert's readjustment would be made. Later the social worker could take up with them more directly the desirability and possibility of doing something for themselves.

Since the parents had ascribed responsibility for their son's problems so completely to others, blaming the school and the playground, the more direct steps involved in arranging tutoring and recreational outlets proved a valuable stepping-stone in helping them accept their own responsibility. It permitted a gradual expression of their own attitudes and at the same time provided some sense of working concretely toward their goal.

In several interviews with the mother the relationship between Robert's behavior and her attitude toward him, and especially her attitude toward her husband, were discussed. There were several interviews with both parents together in which the presence of the social worker seemed to permit them to speak frankly. Each parent expressed hostilities and complaints against the other without the rancor and injured feelings which had occurred in their private exchanges. The presence of an impartial third person, who was concerned not so much with their individual grievances as with their influence on Robert's growth, seemed to make possible a less personalized discussion. The social worker's attitude during these interviews remained impersonal but friendly. She did not take sides but helped them tie up some of their feelings toward each other with their feelings toward

## Failure to Support Child's Dependency 187

Robert and his reactions to them. Though her rôle was unaggressive, she participated in the discussion to the extent of helping them to relate their interdependent relationships, which they voluntarily discussed, to Robert's own sense of insecurity. These interviews appeared to be of significance in throwing more clearly into relief the strains and tensions in the situation and also in affording an opportunity for husband and wife to reach a better understanding of each other.

Later the father, in an interview with the social worker, expressed with a good deal of frankness his feeling of dissatisfaction with his rôle of husband and father. He had arrived at a clearer understanding of Robert's emotional needs, also a clearer understanding of his own difficulties. He had more clearly reached the point at which treatment for himself could be discussed. While he had some grasp of the significance of the present situation and of his own influence in it, his particular problems blocked the way to taking the initiative in improving it. His problems were on so deep a level that the staff felt that only a long-time period of psychotherapy could be of value in helping him solve them. The plan at present is to discuss these possibilities with him and to stand in readiness to offer counsel if and when he wishes it.

The mother, too, has come to a more complete understanding of Robert's need for affection and emotional security. She realizes more clearly than formerly the effect of the tensions and strains of their own problems upon their reactions to Robert. It has become increasingly evident to both parents that his feeling of doubt has been augmented by their ambivalent attitudes. When the treatment began, Robert's immediate and obvious response to their attention and evidence of affection was so clear that with their new understanding of its significance they have been able to accept, at least partially, their share of the responsibility. The mother's



problems seem to be on a more readily approachable level than the father's and it seems likely that they can be dealt with by the social worker, without resort, at present at least, to the more searching techniques of psychiatry.

Robert's attitudes seem to reflect rather clearly certain of his parent's attitudes. While Robert and his mother are both very fond of his father, father and son are neither particularly strongly attached to the mother. Other feelings and attitudes of both parents are also seen in Robert, creating a situation in which conflicts and doubt are seriously interfering with his adjustment.

Up to the present it has seemed best that the social worker keep a good rapport with both parents, since their interrelationship was the most significant contributing factor and was unrecognized by them. It is doubtful how much further this plan can be carried, since they have arrived at a recognition of the ineffectiveness of their own struggles to adjust happily and are now more nearly ready for individual treatment. The father's need for the help of a psychiatrist is evident and logically the next step would be to aid him to realize its value. The mother's problem, thought to be less deep, can probably for the present be treated in the fashion already undertaken in early interviews, that is, a discussion of attitudes and interrelationships.

The outlook for the ultimate happy adjustment of the parents is unpromising in view of their emotional difficulties, but for Robert the possibilities seem better. Within himself are resources which can be utilized, and the more consistent and somewhat warmer attitudes of the parents are giving him a balance which he lacked before. He is finding more satisfaction in successful achievement at school as his reading becomes more proficient. Participation in supervised recreational activities is providing him with another source of satisfaction and acceptance.



## Mary K.

Mary, aged four and one-half, was referred to the Institute by her mother because she soiled and wet her clothing, and because, in the mother's words, she "wants constant attention from me and does not want other people to wait on her."

Mary is the second child in the family. The mother related that she and her husband had come to Chicago when their first-born daughter was four years old. She spoke of herself as a stranger in Chicago. Her husband was a technical engineer and had but little time to spend with the family. Mrs. K., in her loneliness, devoted herself to her daughter. This daughter was killed by falling down an elevator shaft. Mary, who was born subsequent to this tragedy, was cared for with great maternal devotion. Mary had a long series of illnesses that threatened her life and necessitated spending much time in hospitals. These illnesses produced much solicitous care on the part of her mother and a great deal of attention from numerous other adults. A third child, a girl, was born while Mary was in the hospital. Upon Mary's return from the hospital she had to learn to walk again and in many ways acted like a small baby. She appeared to resent the presence of her baby sister and showed her resentment by the development of temper tantrums. Mary had soon to return to the hospital with another dangerous illness. Later another girl was born.

During the first period in the hospital Mary developed pronounced negativism. This was exploited by a nurse who obtained the child's coöperation by suggesting that she do the opposite of the desired action. ("Don't drink this.") After her return from the hospital Mary, now not quite two years of age, resisted her mother's effort to try to train her in toilet habits. After some progress had been made she

would start soiling herself again. Her younger sister was trained almost without effort.

Mrs. K. was an intelligent but high-strung woman. She had a good deal of understanding of the situation and the factors responsible for it but she was emotionally very tense about the matter and realized her difficulties in carrying out a consistent program. She was inclined to over-restrict the child.

Mrs. K. was under stress because of the fact that her husband was out of the home most of the time, usually not getting home until late in the evening. She was clearly concerned over the risk of their growing apart and this obviously increased her tension. She felt that Mary's behavior augmented this danger, because the care of the child cut into the little time she had with her husband and sapped her energy. She felt it so necessary to solve the problem quickly that she tended to abandon each method of control before giving it thorough trial, and this made her behavior somewhat inconsistent. Mrs. K., herself, was expecting to undergo a major surgical operation, a prospect which probably did not contribute to the maintenance of placidity in trying situations. There had been repeated and rapid change of maids in the home. Mrs. K. recognized herself as having a tendency to be over-meticulous—"persnickety" was the word she used.

The psychiatrist pointed out to Mrs. K. that Mary had become accustomed to a rather extreme amount of adult attention and maternal solicitude. This to her was the accustomed mode of life. Now she had been crowded out from such an extreme share of attention by the advent of two younger children. This naturally left her with an unsatisfied expectation of attention. To this she responded by attention-getting devices and by competition with the younger children in being infantile. Mrs. K. readily recognized and accepted this interpretation of matters. The therapist suggested to her

## Failure to Support Child's Dependency 191

that it would not be possible to wean Mary from her accustomed amount of attention suddenly, that it was necessary first to substitute socially acceptable devices for obtaining attention in place of the socially unacceptable ones. She was advised to give the child praise and recognition very liberally for her childish accomplishments and for any assumption of responsibility for her toilet habits.

It was further pointed out that any effort to reduce immediately and directly the amount of attention Mary was obtaining would result in increased dissatisfaction on the child's part and probably would be reflected in an increase of her disturbing attention-getting attempts. It was suggested that only after Mary had been won to positive rather than negative means of obtaining attention would it become opportune to begin to wean her of her excessive need for attention. In the initial and succeeding visits Mrs. K. was advised to avoid all unnecessary restriction and domination of the child, to use non-authoritarian methods as much as possible and to avoid the creation of any unnecessary issues. The psychiatrist suggested that she give affection freely to Mary and that so far as possible she endeavor to appear sympathetic to her.

In the succeeding visits the mother reported that Mary had assumed responsibility for her toilet habits, with the result that soiling had almost disappeared, and when it did occur was slight and apparently accidental. However, Mrs. K. also reported the development of one new problem after another: difficulty in getting the child to bed; the begging of pennies on the street, and the purloining of them from her mother's purse; general rebelliousness; rapid eating at the table followed by wiggling, squirming, and scooting about while the parents and the younger sister were finishing their meal. Yet there was, the parents agreed, general improve-

ment in behavior during this time. Specific problems were partly met by the application of specific suggestions.

On one occasion Mary had been extremely rebellious over a period of several days, "angry at the world," her mother described it. Mrs. K. related her treatment of this situation as follows: "I took her into the bedroom and put my arm around her and talked to her quietly. I told her that the other children would not like her if she acted that way. I don't know what it was but she was very well behaved for the next day or two. I suppose it must have been what I told her about the other children not liking her." Mrs. K. remarked that the problem seemed to be one of general rebelliousness on Mary's part, which if not expressed in one way, tended to express itself in another.

The psychiatrist suggested to Mrs. K. that probably the fact that she took Mary off by herself, put her arm around her and talked to her sympathetically was much more important than anything she said. He pointed out to her that to Mary her mother's love had meant constant and excessive attention, that when she no longer received it she not only resented its withdrawal but that it was natural for her to doubt whether her mother loved her any longer. Mrs. K. then remembered that on the last mentioned occasion Mary had asked her directly, "Don't you love me, mother?" Mrs. K. had replied, "Of course I do. You are my first-born daughter and I will always love you but I don't like you to do some of the things you do and I don't feel proud of you when you do them." Mrs. K. further recalled that that day Mary went around the house singing a song with the words, "Mother loves me." At this point she went on to discuss another incident. During a recent illness of the baby, Mrs. K. began to pet her and talk to her in an affectionate manner. Mary, whom Mrs. K. had not noticed in the room, exploded in a tantrum, saying that she hated the



## Failure to Support Child's Dependency 193

baby, commanding her mother to get away from the baby and stop talking to her like that.

Mrs. K. made three visits to the clinic after the examination. She preferred to take the responsibility for telephoning for appointments herself rather than to arrange them in advance and she applied for no more appointments after the third visit. The problem obviously remained a difficult one at this time.

The intervals between Mrs. K.'s visits proved longer than she had promised that they would be. She felt tied down with her responsibilities for the care of the children, particularly Mary, and with the household affairs. She spent much additional time keeping her husband's accounts, clinging tenaciously to this contact with his work. Her attitude seemed genuinely appreciative of her contacts with the Institute. It is probable that an important factor in her failure to continue treatment was a factor which also contributed to her impatience in her management of Mary—her anxiety that she have time free to share with her husband in his brief moments of leisure, lest they drift apart.

**Discussion.** The mechanism in this case is sufficiently clear. A young mother in a strange city, deprived of much companionship with her husband because of the requirements of his work, pours her attention and affection upon her only child. She loses the child through a violent death; later when the next child, another daughter, was born, pours out affection upon her and treats her with increased solicitude. Repeated and serious illnesses threaten the life of this child and result in her being the center of excessive adult attention and particularly of excessive maternal solicitude in her earliest years. Then the child finds herself deprived of this excessive attention because she is displaced by the successive appearance of two younger children in the family. She adopts attention-getting devices of an infantile character,



develops jealousy toward the younger children and exhibits a general rebelliousness and negativism toward the mother, who, from the child's point of view, has "let her down" for two interlopers.

No doubt it is usually impossible to avoid some sense of deprivation on the part of an only child when a younger brother or sister is born. As a rule it is easy to avoid serious psychic trauma by preparing the child for the event and encouraging the child to identify itself with the parents in their relationship to the new baby. The child should be led to take an interest in and become proud of "our baby." And special pains must be taken to give attention to the older child after, as well as before, the new baby arrives. When, however, as in this case, things happen so as to make the sense of deprivation extremely keen, the child may develop the most profound feelings of insecurity and may pass into a state of emotional desperation quite unrecognized by the adults about him.

There are several natural courses of action to which the child may resort. Since he or she is no longer freely receiving attention he may compel it by attention-getting devices, very likely by the regressions toward infantile behavior. The child competes with the younger brother or sister in being a baby and in requiring the type of care and attention given an infant. On the other hand, the older child may seek to capitalize his relative maturity. He may parade before indifferent and perhaps annoyed spectators all of the things which he can do which the baby cannot do. In the more severe cases the deprived child may develop and express a direct and sometimes intense hostility toward his rival. Occasionally this hostility reaches the point of expression in direct and dangerous physical attack.

In his attitude toward his parents the deprived child is apt to vacillate between overdependence and affection on the

## Failure to Support Child's Dependency 195

one hand and active resentment, negativism, and rebelliousness on the other.

The misbehavior of the child who feels "let down" or deserted by his parents may in turn provoke some active resentment in them. This may give rise to some degree of "rejection" of the child. Such a "situational rejection" seldom goes very deep and can usually be diminished by interpretation of the child's motives to the parent and will usually melt rapidly away if the child's behavior improves.

The general direction of treatment of this type of mechanism is implied in its explanation. The child must learn to share his place in the family with another child. He can scarcely be expected to learn this if his sense of deprivation is too great. It is a primary requisite that he be made to feel reasonably secure in his parents' love. It is often advantageous to allow him to experience some compensations in the form of special privileges appropriately granted him as an older child. The encouragement of a positive interest in the baby as an object of pride and a future playmate is usually of value. During a period of rebelliousness it is desirable that the parents should not unnecessarily reinforce the child's feeling of insecurity in their love by unnecessary conflicts with him. The use of punishment is to be restricted so far as possible, since it is likely to be interpreted by the child as further evidence that he is no longer loved. It is particularly desirable to avoid unnecessary conflicts and punishment over any relationship which develops between the children. Here as elsewhere the insecure child needs affection as a major part of the training program, even in the face of misbehavior. It is desirable, of course, to give attention to the older child in connection with positive and desirable accomplishments rather than in connection with infantile behavior. The withholding of attention so far as possible from his childish behavior is usually advisable if it be accompanied

by the free giving of praise and recognition for accomplishments in keeping with the child's age.

The division of attention between children must be shifted with caution, or the mother may return to report that the older child is improving in behavior and the younger one becoming a problem.

It is usually wise, in the presence of acute jealousy between children, to sidestep or postpone situations which might further jealousy or resentment between them, when this can be done without giving one child a sense of victory through misbehavior.

### Peggy Z.

Peggy, age seven, was referred by her mother because of general difficulty she was having in the management and disciplining of the child. The examination revealed the girl to be of superior intelligence, friendly, vivacious, responsive. There did not seem to be much of a problem so far as the child herself was concerned. There were no other children in the family. The economic circumstances were comfortable. The relationship between the father and mother appeared, on the surface, to be quite good. It was only in the rather lengthy interview which was held with the mother herself that the pertinent factors in the situation became apparent. This interview is so revealing that we shall proceed to it directly.

On entering the clinic the mother immediately made a request to be permitted to sit behind a screen so that she might listen in on the psychological examination. During the psychiatric interview with the child the mother was found sitting on a chair as close to the door of the interviewing room as possible, anxiously attempting to hear what was going on.

The mother was a woman of superior intelligence, who

## Failure to Support Child's Dependency 197

talked with great fluency and as if she were under considerable pressure. Despite this fact, she seemed to be quite detached emotionally as she recited her difficulties, almost as if she were telling of some one else's problems, although the inflections of her voice were sufficient to indicate where she felt stress.

The following material from the record is revealing. It was obtained in response to the psychiatrist's invitation to the mother to state her problems.

There is "lots of difficulty in getting her to do her 'duties.'" The mother is referring by this word not to things which the child is expected to do for any one else, but to the things she is expected to do for herself. The mother complains that it takes much effort on her part to get the child through the morning routine before she leaves for school. She gives many explicit details of the bickering and nagging which go on. She complains, for example, that the child, with little time, will go into the toilet carrying a newspaper with her and will sit there reading it, unresponsive to the mother's urgings to hurry. She complains of the child's "stalling" whenever there is anything to do in a limited length of time, limited, at least, by the mother's dictum.

There is "tremendous trouble" at meal times, dawdling again. "She's always got to have a million and one things going on all at once. At night it's the radio, supper, and drawing, all together.

"She's afraid of me. To begin with, I was very strict with her. Now my (inadvertent) gestures make her cringe. Now, if I don't shout, she doesn't mind.

"She lacks initiative. She will come and ask me if she may do things which it is evident she may do.

"I have trouble getting her to brush her teeth. One afternoon I had brushed her teeth for her. I compared them to those of a friend of hers who was there whose teeth were not brushed. I said, 'Whose teeth look better, yours or Barbara's?' She was heartbroken because she felt that was not the thing for me to do.



"She's afraid of the things I'm going to say to her friends. If I join her when she is with some of them she gets that 'anxious look' which seems to say, 'I wonder what mother is going to say or do now.'" The mother gives an example from a recent experience: She had allowed the child to play on an open playground where there was a small wooden shelter. It was a sunny day and she went out to see how Peggy was getting along. She found her in the shelter rather than out in the open. The mother said, "For heaven's sake, what are you doing in this stinking little room? Why don't you go out in the sun?" The child was ashamed of that. The mother talked to the other children about it, too, and tried to get them to leave the place, but "you know how children are. They rebelled against my interference. I forced her to leave and she was pretty unhappy about it.

"She is embarrassed if I try to join her in her play. Once she was jumping rope with some other children. I asked if she would let me jump double with her. She was embarrassed and then I jumped rope with the other children, one after another, and they seemed to enjoy it and afterwards she wanted to jump rope with me, too, but at the beginning, you know, she must have had that insecure feeling of wondering if I was going to be ridiculed by her friends. . . . Sometimes when I take myself to task for condemning her before her friends and want to make up by lavishing praises on her before them she is embarrassed. She doesn't seem to like it.

"There is always pulling back and forth regarding bed times, baths, etc. She will stall me off by starting to tell me something which she knows will interest me. She fights getting into the bath and getting out of it. She enjoys being in the tub, but doesn't cleanse herself.

"She doesn't have all my attention except when she is getting ill and then I am very anxious about her. I am also very anxious about her school. I am quite ambitious for her. I haven't had much experience with children so I don't know if it is natural or not, but she giggles a lot in school and when six children are involved in an affair, she is the one who is caught at it. . . . When she once makes a contact with children and becomes their friend, she is very devoted to them, but in a new situation she is pretty panicky about it.



## Failure to Support Child's Dependency 199

"I can't seem to join her in anything such as play for play's sake. I seem only able to act spontaneously with her in serious things like her school work. When Peggy was younger I did everything that was necessary for her, in a very religious manner. Whether it was convenient or inconvenient for me, it was done. But when it came to the playful moments!" (The mother shrugs her shoulders helplessly at this point; apparently there was bankruptcy in her relations with the child on this level.)

She was then asked to give a sketch of her personal life. She stated that she was the third of four children of a penurious father and an indulgent mother. Two older sisters had married outside the family's religious faith. The family was engaged in the coal business which was, at that time, very profitable, and there had been more than enough money for all their needs, but there was such constant squabbling between the father and mother over the use of this money that the informant became "afraid of even the necessary use of money." As a child she would deprive herself of the use of clean handkerchiefs, for example, and would never ask for paper for her use in school. "I put myself in an embarrassing situation at school in order to avoid conflict over money at home."

She stated that before she was courted by her husband she had not been on warm friendly terms with men and that her social life had been limited. She stated that she had never been able to get any pleasure out of clubs or associations, and she rationalized this largely by pointing out that she was brought up in a neighborhood in which her family was isolated because of differences in the religious faith. She summed up her social position, however, by stating, "I really didn't know and don't know how to get along with people."

With regard to marriage itself she admitted that her courtship was not a particularly fervent one. She said: "I was

not particularly interested and I was not particularly sure that I wanted to consummate the friendship in marriage. . . . I was interested in marriage in a general way but you know how you pick up ideals and there is no living person who can come up to them. Mr. Z. was very friendly, an easy-going type, and I thought of all the people I knew he was the most desirable, but it was not a marriage which was the outcome of a burning love affair." Discussing the marital relationship, she said, "To begin with, I didn't get a lot of sex enjoyment out of marriage before the child was born." The sex relationship continued to be unsatisfactory although her husband was quite considerate of her. She rationalized her sexual indifference with the comment, "Of course, it depends a good deal upon a person's physical condition, you know."

Then, regarding her pregnancy: "I was not at all interested in becoming pregnant. We were almost immediately in financial difficulties after being married." The marriage was a "match to the gasoline" of her own parents' bad relations. Because her two older sisters had married outside of the religious faith of the family, her mother was so glad that she was marrying within the faith that she planned an elaborate wedding and a "gorgeous trousseau." The informant's father did not enter into these plans, however, and when the mother borrowed money in her own name to pay for it, there was a blowup and subsequent divorce. At the time of the marriage the husband had broken up a partnership with his brother and had gone into business for himself. He had overestimated his prospects and their plans for the new home had been expanded accordingly. Then the financial bottom dropped out of his business. The informant presented all this as a rational basis for not wanting a child at this time. But when she was asked if she would have wanted a child under better circumstances, she replied, "I don't know. I

didn't know whether I liked them or didn't like them. When I was getting married I didn't know if I would want children or not." Then she went on to speak again of her husband's financial affairs, how he did not take with sufficient seriousness the difficulties they were in, while, on the other hand, she skimped and saved. "My husband was very happy over the pregnancy. When I tried to tell him about the expenses that were involved, he spoke of our luck changing with the birth of a baby." She was "very depressed, very depressed!" during the pregnancy. "I went around with my face as long as a poker. I could not make my husband face the facts (of the financial difficulty). I was depressed, worried, and heartsick at my husband's attitude." The husband lost his business in July and the baby was born in September. She confessed that early in the pregnancy "I tried all sorts of remedies but I was very much afraid of actual abortion." She continued her attempts with these "old wives'" remedies for about the first six weeks of her pregnancy. Throughout the pregnancy she was nauseated and her appetite was very poor. Furthermore, "I never thought about the actual baby; I only thought about myself. I thought about the financial circumstances but I never thought about how we were going to raise the child. I never read any books or did anything in preparation for her coming." She described the last two months of her pregnancy as being full of heartache.

She said that when the baby came, "although I can't say that I felt any deep love for her, I became a very conscientious mother. I didn't feel any deep love when they brought the baby in to nurse, and I didn't feel as if it were a part of me." The nursing was a very painful process. There was not enough milk. The nipples cracked. She had to stop breast feeding the child at one month. When she came home from the hospital "the baby was cranky and I thought it was due to my aggravation influencing the milk. . . . I had read

about how it was better for the baby to be breast fed, and I felt guilty about not nursing the child and that is how the conscientiousness started. I felt that I would have to do everything in my power to make up for the fact that I was not giving the baby the breast."

Further, "I was afraid that the baby was not going to live. I always had that fear. I thought that through my clumsiness I was going to choke the baby or something. One of the things that annoyed me about nursing her was that I had heard that one must be careful to keep the nipple away from the nostrils or they would become clogged. I didn't easily adapt myself to handling the baby. In feeding it I was clumsy and I was afraid it would choke (that is, by having the nostrils blocked by the nipple). If the baby slept longer than I thought it should, I thought it had died in its sleep and I would put my finger near its nose to see if it breathed because I was sure she had died. Then when I gave the baby the bottle and she didn't finish the milk, I would be very upset and very persistent and keep forcing it. She would push it out and I would keep forcing the bottle back in and I would not give up until the milk was gone. Then, if the baby vomited I was frustrated. I was 'fit to be tied.' I would take her to the doctor every month although I couldn't afford the five dollars, and I neglected everything else. The only thing that mattered in my life was the baby having proper care. It was good that my mother stayed with me and cared for the baby. I handled her as little as possible. I was afraid I would do something that was not right."

**Discussion.** The mother's own statements with regard to her maternity are themselves indicative of the essential problem involved in the case of this child. It seems obvious that here is an emotionally immature woman whose dependent needs have never been satisfied in her own life and who entered marriage unable to assume normal attitudes toward



## Failure to Support Child's Dependency 203

motherhood. She entered marriage for its apparent social advantages and, one suspects on the basis of the information, in order to satisfy her wish to be dependent, which wish had not been satisfied in her relations with her parents. Child bearing carried with it a responsibility which robbed her of the status which she wanted. Her husband's welcoming attitude toward the coming child had established it as the mother's rival in the situation from which she had expected so much for herself exclusively. Her aversion to bearing this child is explicit. The rationalizations she presented in the interview were transparent. Her conscious attitudes toward the child, built upon the basis of society's expectations, were exaggerated because of the guilt she felt over her deep emotional rejection of the child. Having certain conscious knowledge of a mother's duties, she wanted to care for the child, she wanted to give the child all possible advantages. Because fundamentally she was hostile to the child she had to protect her consciousness against realizing that hostility. As a result, she so overacted the socially approved maternal rôle that she presented a picture of almost ridiculous over-anxiety.

This woman's hostilities were very close to full conscious realization by her, and it was because of this that she was able to put so clearly into words the evidence from which it was easy to diagnose a set of motivations frequently present in over-anxious mothers. The mother's own statement clearly revealed the differences between her social attitudes toward the child and her deep emotional reactions. She said in the interview: "When Peggy was younger I did everything that was necessary for her in a very religious manner. Whether it was convenient or inconvenient for me it was done, but when it came to the playful moments!" then the helpless shrug of the shoulders. Here, in this one statement, is revealed her knowledge of the relationship which should exist between mother and child; her exaggerated emphasis on this



duty, due to her sense of guilt; and, finally, in the last futile shrug of the shoulders, the essential lack of a spontaneous, warm, resonant emotional attitude toward the child.

The child's problem behavior, too, revealed well enough a child who sensed some of the fundamental attitudes of the mother toward her and who reacted with a sense of insecurity and with thinly disguised reciprocal hostility to the mother.

It must be emphasized that not always is the situation as clear cut as in this case. The reasons for the underlying hostile attitudes are not always so apparent, nor are the hostilities themselves so close to the surface. Most frequently the picture presented consists largely of over-anxiety and this may be so adequately rationalized through reference to some real situations that the underlying emotional problem is not easily discernible. It must also be remembered that not all mothers who, for reasons traceable to their own emotional development, are averse to maternity and experience some feelings of hostility toward their children, are so bankrupt in their obvious relations with them as this mother is with her child. Many women succeed admirably, on the basis of other elements in their characters, to effect a reconciliation with their situation as mothers so that the clinical problem which we refer to as maternal rejection does not develop. Neither irritability nor anxiety by itself indicates that a mother rejects her child. Under the most favorable circumstances motherhood is no easy task. The mother with a first child is particularly likely to be somewhat concerned over some of the details of her responsibility. At times problems of discipline, which any healthy baby may present, or extraneous matters in the mother's personal life may influence her patience and temper. But in the emotionally healthy mother these are incidents of no extensive significance.

## Failure to Support Child's Dependency 205

The most skilled and most prolonged type of therapy is necessary when the problems of this type are very severe and the outlook for a fundamental change in the mother is doubtful. In cases of very young children the most hopeful treatment, according to the present experience of the child guidance clinic, seems to be careful foster home placement with substitutive maternal care of an emotionally more normal sort than the child's own mother offers. Often this is not feasible. The mother's guilt does not permit her to consider placement, since this is too clearly an admission to herself of her personal failure. In such cases institutional placement may be acceptable because it is more easily rationalized as "something wrong with the child."

### Sam G.

Sam G., fourteen years old, a second-year high school student, was referred by the Juvenile Court following his arrest for making sexual overtures to a seven-year-old girl in a darkened motion picture theater. He had been examined at the diagnostic clinic of the Court where he had been found to be physically developed beyond his years and where an intelligence test had revealed mental ability equivalent to that of a very superior adult. He had discussed the facts of his offense frankly with the Court Psychiatrist but otherwise the preliminary interviews with him were quite unrevealing. He had no idea of his reason for obeying the impulse to approach the little girl, and attempts to explore the possible motivations by means of direct questions were met by him with a supercilious, argumentative, and, at times, rather sharply aggressive attitude.

The history revealed that he was the youngest of six children in a poverty-stricken immigrant family into which he was born seven years after the latest born of the older siblings. His father, a chronic alcoholic, who had tyrannized

over the family in his lifetime, died when the patient was an infant. His mother, a simple, hard-working, rather dull peasant woman, had indulged and pampered him. Until the present year he had had to stand for considerable domination and imposition by his brothers and an older sister. Recently he had begun to rebel against this treatment and had isolated himself from the other members of the family with the exception of his mother, toward whom he continued to show a shy affection.

For some time before the father's death the family had not been economically independent. Because the earnings of the sister, who was the oldest child, and of the brothers had seldom been adequate, the help of social agencies was often necessary. Frequently food was scarce and one of the more serious causes for difficulties between Sam and the other children was that he ate so much and would frequently raid the family larder to satisfy his ever-present appetite.

The boy appeared to have few friends and these were not close. A brother said of him: "He's an outcast because he cannot find any boys of his intelligence level and with his interests." These interests, however, were limited. He was an omnivorous reader of the best literature and had a deep disdain for "trash." He often engaged in disputes with some of his less intelligent brothers because he preferred symphony broadcasts to jazz. But he had no interest in athletics, no hobbies, none of the usual adolescent social preoccupations. At school he was sporadically a brilliant student but frequently he became indifferent, played truant, and tended to let his work slide. He expressed a wish to go to work as soon as possible so that he could make enough money to satisfy his immediate small needs, especially for food. He took a disparaging attitude toward college graduates who were "walking the streets and starving." Nevertheless, he also expressed interest in a career in archeology and wished

that he might one day have the social status and financial security of a professional man.

**Discussion.** It seemed clear that his offense was not the act of a mental defective or of a deteriorated character. Despite the antagonistic attitude which he had assumed in the original psychiatric examination, he appeared to be rather frightened and bewildered by his lack of conscious knowledge of his motivations and by his inability to control his impulses. Because of this it was considered advisable to attempt psychotherapy. We must preface an account of this course by some general statements concerning psychotherapy.

Psychotherapy literally means treatment by means of the mind. It is in general applicable only in those conditions, diseases and disturbances which are not of bodily origin. In other words, it can be of use only in mental and emotional disturbances and not in real organic disease, though it must be admitted that even in the treatment of organic disease there are psychological problems and the best doctors are also good psychotherapists. The practice of psychotherapy depends on the fundamental fact that psychological processes can be influenced by psychological methods. Psychotherapy makes use, in a more precise and technical manner, of the generally observed possibility that attitudes, feelings, and ideas may be influenced by exposing them to other attitudes, feelings, and ideas. We are all familiar with common sense examples of effects produced by one personality upon another. A cheerful, buoyant person helps a gloomy, pessimistic one over a difficult period. An individual with a clear point of view dispels the doubts and fears of one who is confused. Psychotherapy of a non-technical order such as this is found in our everyday lives. While the matter is not so simple in the treatment of neuroses and in character and conduct problems, these examples serve to indicate the possibility of dealing successfully even with such problems. The



demand, then, is for a systematic knowledge of mental processes and the variety of their manifestations, and it is the province of the psychiatrist to meet this demand.

Psychotherapy can be recognized as being broadly of two types. The older and more generally applicable type does not depend on the rational insight and understanding of the patient. Of paramount importance here is the prestige of the physician, for upon it rests the power of the treatment, no matter what superficial forms the latter may take. Encouragement, persuasion, and suggestion can in some instances perform apparent miracles. Sometimes an electric current or hypnosis may be necessary. Sometimes an appeal to faith, a bit of plausible philosophy will do the trick—at least for a time. The physician, as a powerful, sometimes gentle, sometimes firm, mother or father image, provides the outside support which the childish ego of the neurotic person needs. But with many problems, such techniques are futile and, even where they are helpful, they leave the underlying cause untouched, though often this is unavoidable.

The other forms of psychotherapies, the newer ones, are a development of the last forty years. They depend upon a point of view which is derived from evidence that neurotic illness and that deviation of character and conduct which we have been calling “problems” have a purpose in the life of the individual. Neurotic symptoms and character manifestations are seen as satisfying unconscious, fundamental wishes and needs, which have been denied more direct satisfaction. The individual is looked upon as being impelled to act, feel, and think in certain ways because of the pressure of unconscious motivations having their roots in the biological nature of man and in the history of his social experiences during the first five or six years of life. Rational psychotherapies attempt to bring the individual to an inner view of himself in terms of such factors as these and to help



re-direct energies which have been sidetracked in the individual's effort to meet his unconscious wishes and needs. The process of treatment, however, does not leave the patient in a vacuum in which to work out his problems. The person of the therapist plays a very important rôle. On him are focussed attitudes, wishes, motives which previously the individual had directed toward his intimate associates and toward the world at large. Through his relationship with the therapist, the theory runs, the patient recapitulates the history of his emotional development in relation to parents, brothers and sisters, and others who have been emotionally significant. The function of the psychiatrist, then, is to understand and make the patient aware of the emotional logic of his feelings, attitudes, and ideas, and to bring these into connection with the events of the individual's actual life. The final effect of treatment is dependent not simply on the intellectual understanding which the patient carries away but also upon rearrangements in his attitudes and feelings and purposes which may occur as the result of the working through of old attitudes, feelings, and purposes in the terms of the new understandings.

The following material from the record of the psychotherapeutic treatment of Sam illustrates one of the newer types of therapy. It must be looked upon as an effort to deal with his attitudes largely on an intellectual basis, though inevitably there is some working through on an emotional level also. Nor can it be looked upon as a usual type of therapy with an adolescent boy of fourteen. This is an unusual boy, a boy of superior intelligence who has precociously acquired adult knowledge and points of view. The effort which is being made in treating him is not exclusively rational, as may be concluded from the example of this type of treatment which is quoted. The psychiatrist is not simply attempting to give the boy an intellectual view of himself

and an opportunity for some emotional discharge, but is also "supporting" him as much as possible without interfering with the more important problem of giving him a chance to work out his own destiny.

In the first treatment interview with him, Sam began quite spontaneously to speak of his chagrin over the fact that a girl he once knew commented of him, "What a figure!" He had taken this to mean that his hips were accentuated, with the implication of femininity. He dwelt somewhat on the narrowness of his shoulders in this same connection. He spoke of the inferior position which he had in his family, of the contempt in which he was held by his siblings. He seemed quite disturbed emotionally.

In the second interview, he mentioned his very first memory which dated from the first four years of his life. "I was watching a guy delivering bread to a grocery store." Then he spoke of dreaming, when he first entered school, a lot about having money. These dreams were repetitive and were always marked by the feeling: "This ain't going to be real when I wake up." He also mentioned a craving for sexual intercourse which had appeared in the last two or three years. But his only actual sexual experience had been one in which he sat on a bench in a park with a girl his own age and felt her breasts. He had not wanted to do anything further.

He spoke about being scolded by his sister and his brothers because he ate too much and about stealing some money from his sister when he was nine years old. He confessed having sexual fantasies with regard to some of his middle-aged teachers. He said: "I like to eat a lot; I always think of eating." He referred to the fact that he would save his pennies and buy stale pies which he could get at a discount. His closing statements in the interview were concerned with his toying with a plan for running away from

"that madhouse at home," but he was all confused about it because "I want to stay here for help. What are you going to do for me?"

The psychiatrist pointed out to him his preoccupation with money, food, and sex, and referred also to his last question as to what would be done for him. He was told with regard to the latter : "It is not what I will do for you, it is what help I can give you to help you see things more clearly."

In the third interview Sam spoke of a settlement house at which attendance had been arranged for him. He had had a pretty good workout in the gym. It was the best gym possible for him but it wasn't a very good gym. "If I had money I could go to a better gym." He spoke also of having gone into a department store the previous day to steal, but he had been unsuccessful. "I knew I was going to do wrong but I couldn't help myself." He confessed to petty thievery in the past at which he has never been caught. From here the interview went on as follows:

"Aren't you going to do anything if I tell you what I am going to do?" (That is, such things as sexual activities, stealing.) The psychiatrist implied that he was not interested in checking up on him as a policeman. "Won't you be an accomplice?" The psychiatrist replied, "I am a doctor. I can only help you to help yourself, I can help you to understand your reasons for doing what you do and for feeling the way you do. That is as much as you can ask from me." Sam went on then to comment on his need for spending money, on his need for a job, therefore. If he could have a job or spending money, he would not have to steal. Frankly, he was expecting a "handout" here, he said. The physician connected this attitude with his comments about dreaming of money and recalled to him that in the previous interview he had asked the psychiatrist for tobacco. He replied, "I'm selfish. I spend all my money on myself." He left nothing in the house if he

could help it. He didn't care whether there was enough food left for his brothers and sisters. It was indicated to him that his excessive appetite, his dreaming of money, the early development of his demanding attitude toward the psychiatrist all indicated an essentially receptive "wish to be taken care of" attitude. He responded with an emphatic "That's right!" and went on to mention other sponging proclivities. He admitted that the stealing he had done was a more aggressive aspect of this, and he himself said that his general egoistic attitude had the same basis.

The physician then called to his attention that his disparaging of the settlement house opportunity he had received was a part of this general tendency. By deprecating what he received he remained in a position to demand more. The patient then pointed out that others have lived better than he, have gotten better things, that he only wanted what other people have. Then he went on to speak about the hopelessness of his case. It was pointed out to him that this was an attempt to present himself in a helpless position and thus deserving of the psychiatrist's help. He was told: "You are asking me to treat you as a young child. I am trying to help you to treat yourself as a grown-up." Then he said, "I am intelligent, my mind is that of an older person, but after all, I am young." The physician rejoined, "You're saying: 'I'm a child, take care of me.'" He said, "Psychiatrists should have experience of life, should have gone through the things you are trying to treat. You are a white collar guy, you and the others here. You don't know how things are; you only read it in books," and went on to make other disparaging comments. These deprecatory attitudes toward the physician were then presented to the patient as a spiteful reaction to the fact that the physician seemed to be refusing to give in to his childish demanding attitudes. But he denied all this. "All that's wrong with me is my sex



side, my financial side, and my physical side. The most important thing is the sex side, next is physical, and next is financial." It was then indicated to him that thus far most of the things he had revealed indicated a wish to be taken care of, a wish to be fed, and that perhaps his talk about wanting to have sexual relations was just bravado.

Then Sam mentioned some rather extreme, ambitious fantasies, spoke of wishing to be a philosopher, a wise man, and then while lighting a cigarette, which he rolled himself, went on to say: "I guess I don't have to ask you for any tobacco to-day. I bought some. I wondered why you gave me some tobacco the other day and allowed me to smoke." (The tobacco had been given to him as a friendly gesture so that any hostilities which he might develop might be scrutinized for causes arising within himself rather than in the real relationship with the physician.) He then made a conciliatory gesture toward the physician, admitted that, despite implications to the contrary, in his previous comments, he felt that the psychiatrist was trying to help him to help himself, and that in all probability the psychiatrist understood him pretty well. He said further: "I was figuring this. If I should grow up and later you knew me and I had changed, if you would repulse me, if you would block me from entering good circles." (He here exhibited some competitive attitudes toward the psychiatrist and at the same time showed some anxiety about the way the psychiatrist really felt toward him.) He went on to give further indications of his wish to compete with the psychiatrist on his own level and then to mention how he failed to exert himself at school, how he would like to attain professional status and income some day, but that he didn't like to study, didn't like to take books home, didn't like to comply with the rules of the classroom.

It was pointed out to Sam that despite his egoistic desire to attain status, he did not wish to exert himself in return,



he did not wish to put anything into his career, he wished it to happen to him, that this was also a phase of his demanding, receptive attitude toward life. He was thoughtful for a few moments and then emphatically agreed with this but immediately went on to challenge the psychiatrist again with questions as to what the latter would do if he were to commit any delinquencies. He again stated as he had previously, "You'd be an accomplice if you didn't tell the police. You'd have to tell the police." The psychiatrist tacitly denied this. The patient said, "You're just like the Creator. He gives us our way for evil or good and is superior. Then when trouble comes along he is critical." His statement was re-phrased to him as follows: "You're telling me that I am allowing you to drift here without intervening with my immediate help and will later criticize you. What you really mean is that you are allowing yourself to drift in life. But it is easier to think that I feel critical toward you than to accept your self-criticism." He said, "Have you got time to think about me?" The psychiatrist said to him: "You seem to feel jealous of the possible other patients I have. You seem to feel that you will have to share with other patients. You are really concerned with whether or not I have enough for you, if I have other patients also." The interview was closed at this point.

A week later, in the beginning of the fourth interview, Sam reported immediately that he had had four dreams since the last visit. He related each of these four dreams and then elected to talk about the following one of the four:

The lady in the family grocery store was leaning over the counter. Her breasts were hanging over the counter. I tried to touch the breast with my elbow and she moved away. Next, I tried to touch the breast with my hand. She got mad. Finally I tried to grasp them with both hands. The breasts shrivelled up and disappeared above the neck line.

At this point we must digress from the actual material to indicate that dreams have been found to have a relationship to the unconscious wishes and attitudes of the dreamer, and that if we can understand the dreams of a patient we can understand the meaning of his illness.

Returning to the patient, he said spontaneously that in reality this lady in the grocery was a woman of about forty whom he saw when he went there on errands. He actually thought of fondling her breasts when he entered the store, and then added, as an after thought: "I always figure in my sexual fancy to get physical pleasure and financial aid—money from women—at the same time. But her face in the dream is a mother face and I revolt at the idea. When she got real mad in the dream, I was ashamed and horrified because I figured she'd tell one of my relatives. I was just horrified when the breasts shrunk. It seems they were eluding me. Sex pleasure is elusive."

It seemed that the dream, together with the things which he said in regard to it, and which statements had an intrinsic relationship to the dream itself, revealed the following: that there was a wish for a childish relationship to his mother, a wish to be taken care of as he had been as an infant, that there was a feeling attached to this wish, that his longing is not satisfied. Further his sexual attitudes toward woman were simply a masquerade for his childish dependent wishes. He himself said that he could think of sex matters only in relation to receiving something from a woman, money, the money he bought pies with to satisfy his exaggerated hunger. More than that, the dream seemed to be the patient's manner of refuting what had appeared obvious from the previous interviews, that he had an excessively demanding attitude toward life. The dream was also his manner of saying: "You told me that I am selfish but, behold, I am a

child who has not been given anything; even the breast has been refused to me."

The opportunity was taken at this time to discuss some of these matters with him. He insisted that his thoughts were exclusively sexual in the adult sense and denied the essentially infantile meaning of his attitude toward women. The psychiatrist then indicated to him that the adult sexual connotations he gave to his interests in women were only the language of the present used to express something of the past. He could accept his relationship to women if he could look upon it as an essentially manly relationship. He could not accept the idea that he was essentially an infant in relation to women and had only childish desires of them. There was some discussion of this and with final acceptance, he responded, "That's right. I have more pleasure in feeling the body than I would in intercourse. Intercourse would take too much out of me." The essentially selfish, childish character of his attitude toward women became explicitly clear here.

Following this, he chose to discuss another of the four dreams, but nothing much came of it. The interview then continued as follows:

PATIENT: Are you giving the patients around here any stuff? (*It was just before Christmas.*)

PSYCHIATRIST: No.

PATIENT: Don't you think you should? After all, a box of candy or some fruit cake, it only costs about half a dollar. (*He went on to describe a delicious fruit cake with much gusto.*) Boy, that's the cream of delight! (*He borrowed some tobacco and a match from the psychiatrist, who indicated to him his persistence in his receptive demanding attitude.*)

PATIENT: Well, Christmas, everybody should give on Christmas.

PSYCHIATRIST: Are you planning to give gifts?

## Failure to Support Child's Dependency 217

PATIENT: Oh, a tie or a pencil. You need a pencil. That's all I could give you. You have a large salary; you could give me more.

PSYCHIATRIST: In which case, you could figure you would come out ahead on the receiving anyway because you would be getting more for less.

PATIENT: Do you go to lunch? (*The interviews were held at the noon hour.*)

PSYCHIATRIST: No, I don't take lunch.

PATIENT: I thought if you did, I could walk you to the restaurant.

PSYCHIATRIST: You would expect me to buy you lunch then, wouldn't you?

PATIENT: Yes, it would only be natural that you should ask me in. (*He went on to speak about the athletic instructor at the settlement house who had given him special opportunities and privileges, had promised to further his interests at the settlement house, had exhibited in general a generous warm attitude toward him.*)

PSYCHIATRIST: You are saying in other words, "If you will not give me anything, others will." You are making an unfavorable comparison with me, you are criticizing me because you don't think I am giving you anything.

PATIENT: (*He at first denied this and later admitted the implications of the statement.*) Don't you have a gym here for the big boys like the playroom for the little boys?

PSYCHIATRIST: No, we have not found one necessary.

PATIENT: Don't you think the State should do something about that?

PSYCHIATRIST: You are saying: "You give others something but you give me nothing."

PATIENT: Don't you have charity workers here? We are a poor family. They might get me some shoes or something.

PSYCHIATRIST: You are trying every possible method to have your demands on me satisfied. You are trying to shame me, you are trying to arouse my sympathy, you are expressing some anger toward me. (*It was indicated to him that in the treatment situation the psychiatrist gave him his interest in his problems, gave him the benefit of his professional training, that the patient had to accept the fact that no other sort of giving was possible under the circumstances.*)

PATIENT: I appreciate what you are doing for me here. Other guys might not. . . . Well, have you solved the other dream?

PSYCHIATRIST: (*Indicated to him that he was already aware that there was insufficient material to understand the other dream, that his mention of it was simply a disparaging attack as a reaction to the frustrations to which the psychiatrist had submitted him.*)

PATIENT: Why can't you give me something personally? Wouldn't that help me, if you gave me a pair of shoes or something?

PSYCHIATRIST: That would not help you, coming from me. That would only preserve in you your present childish demanding attitudes toward me.

PATIENT: If I didn't come back, would you be sorry?

PSYCHIATRIST: I would regret it. I would make several attempts to get you back. I would write to you. I would save some appointments for you, and if finally you didn't come back I would have to resign myself to thinking that it was too bad. I would not force you to come back because you can get here only what you wish to try to get yourself.

PATIENT: What do they call you around here besides Doctor? Isn't there some other name I can call you? Haven't you a first name? What is your first name?

PSYCHIATRIST: (*Denied Sam this information as not pertinent to the treatment situation.*)



## Failure to Support Child's Dependency 219

PATIENT: Well, then, I will have to call you 'D.R.,' and if I can't call you by your first name, I want you to call me Mr. G.

PSYCHIATRIST: (*Called attention to Sam's attempt to disarm him by bringing him down to a personal level. If he could reduce his relation to the psychiatrist to a personal one, then he would not be compelled, as in the treatment situation, to face things within himself. His retaliatory attitude as a reaction to his failure to do this was brought to his notice.*)

PATIENT: (*He made some disguised, although readily recognizable, deprecatory statements about the psychiatrist. He commented on the fact that he had read somewhere the quotation "The world owes me a living."*) It does, doesn't it?

PSYCHIATRIST: (*His essentially demanding attitude toward life as repeatedly revealed previously was indicated as being in line with this last idea. It was pointed out to him that his formula was: "If life does not give me what I wish and deserve, I will demand from it and if necessary, I will take from it what I want."*)

PATIENT: (*Final statement*) It's too bad I wasn't born rich. How much I would get to eat . . . capons and fruit cake and sweet wine and Russian cigarettes—Boy, if I only had money!

In the next interviews he reported a dream in which a girl who was giving out cigarettes to a lot of other boys had to be coaxed to give him one. The cigarettes were hidden between her breasts. She finally gave him one grudgingly. The thoughts that came to him about this dream all tended to indicate the feeling that he had been deprived. In effect, the dream said for him, "The others were given and I didn't receive anything. I had to ask. I had to demand." His response to this interpretation was emphatically as follows:

"That's right! That's why I asked for so much. . . . I had plenty to eat but not good stuff."

In this dream, the scene of which was laid in a dance hall, he appeared as rather alone while the other boys were crowding around the girl and receiving her favors. About this he said, "I don't make girls as easily as other guys. In the dream I felt different, I had to go to her and ask her and it wasn't easy. I can't associate so freely as the others do." The psychiatrist commented, "Association means give and take." The boy rejoined, "I mean I can't talk freely to girls." The psychiatrist again commented, "Talking freely means giving of yourself freely." The boy rejoined, "I'd give of myself freely if I could. I want to but I can't."

PSYCHIATRIST: The reason for that is that you have a deeply ingrained feeling that you must not give anything because you have not received yourself, and that what you have received has been poor. It is as if deep within yourself you were constantly saying: "I haven't received, therefore I can't give." This is what the dream would indicate.

PATIENT: I don't sense that. I simply can't do it (that is, associate freely with other people). It is physically impossible for me to talk to people. (*It must be noted that this boy had little actual difficulty in expressing himself.*) . . . I don't feel at all that I don't want to give because I haven't received. Every phase of me wants to associate with others.

PSYCHIATRIST: But that means giving to others as well as receiving from them.

PATIENT: I want to associate with people to make me feel better . . . (*a pause*) . . . to get—Oh, I see!!—but I want to be able to make them receive me cordially. Of course, I want the pleasure of their company. I want to associate, I want to give, but I don't know how. I can't do

## Failure to Support Child's Dependency 221

it. What I really want is their approval, and in order to get it I want to give my interest and time, but I can't.

PSYCHIATRIST: You are saying now, in other words, that if you must give you want to give only for what you can get. The emphasis is on what you want to receive.

PATIENT: It is very subtle but I see it. I don't have the power in me to give out.

At this point we leave the actual illustration of the treatment of Sam's case. At the time of writing it is still in progress, with some twenty hours of interviews behind us. There have been difficult periods during which the boy's hostilities have risen high but he has continued to return regularly and there has been increasing insight and understanding of his difficulties, though they are far from cured as yet. Nevertheless, Sam has applied himself to school work and has made up a large number of incomplete assignments with the result that he has been advanced to the next grade, whereas he had been in danger of complete failure previously. He has made some definite efforts to look with a different point of view on himself and his relationships, though he has succumbed often enough to feelings of hopelessness which often merged into defiant attitudes of the sort which he had originally presented.

The outlook for the final happy outcome of this case is not too bright. The boy exhibits a too strong tendency to be dominated by his pleasure motives, that is, to respond too completely and with too much enjoyment to his immediate wishes and impulses. Emotionally, his development is limited. He expresses directly and without much disguise many attitudes and feelings which in most individuals are heavily layered over by their training and experience in life. It is this last factor, however, which has made the case a suitable one for illustrating which processes are involved in an emotional problem and its treatment.

The psychiatrist has in this case been considerably more active than would have been deemed advisable in the case of individuals whose unconscious tendencies were not already so close to conscious realization. However, in a less dramatic manner and developing much less rapidly both as regards the patient's revelations of himself and the interpretations of these revelations to him, this is typical of the activity which goes on in a psychotherapeutic situation where the ultimate aim is to give the patient rational command of himself and his destiny. It is clear that, in essence, the attempt is to bring to conscious realization unconscious impulses, wishes, and tendencies and their interconnections when they, in their original state, are outside of the control of the rational personality and are thus capable of producing irrational conduct. It seems evident that in this boy the sexual problem for which he was referred was merely a symptom of the real disease, which we have observed to be his emotional fixation at a very early infantile level.

## Chapter XIII

### PROBLEMS ARISING FROM FAILURE OF PROPER DIRECTION, TRAINING, OR CONTROL: CASE STUDIES

#### Bertha

**B**ERTHA was brought to the clinic because of excessive masturbation. Although she was only six-and-one-half years of age, she had already had five different placements outside of her own home. Twice she had been placed in receiving homes. She had lived with four different families and had been called by three different surnames. Briefly her story was this:

Little was known of her mother. She was a waitress and had lived in a lodging house with her two children, Bertha, age three years, and Henrietta, age eighteen months. The caretaker who ran the lodging house was sorry for the mother and considered her overworked and overburdened. The mother deserted her two children, leaving them in the lodging house. The caretaker, without reporting to public authorities the disappearance of the mother, placed Bertha with friends of hers, a married couple to whom we shall refer as Mr. and Mrs. A. The A's had a defective crippled child. Bertha's sister, Henrietta, was placed through a small private child placing society. Later the case accidentally came to the attention of the State authorities, and an investigation into these placements was made. The father of the children was never located. The caretaker reported that the mother had spoken of a husband in connection with past



events in Cincinnati. He could not be traced. The visitor for the State did not approve of the placement of Bertha despite the fact that mutual bonds of affection had grown up between Bertha and her foster parents. The visitor claimed that separation of the two sisters was unwise, that Bertha, then four-and-one-half years old, had much housework to do, and that the social standards of the foster parents were questionable. She removed Bertha, placing her in a temporary receiving home, then in a temporary foster home in which she underwent a traumatic sex experience at the hands of an adult male boarder. The worker learned of this, removed Bertha and returned her to the private receiving home.

The worker then visited Mr. and Mrs. C., foster parents of Bertha's sister, Henrietta, and persuaded them to take Bertha also into their home. She suggested that if this were not done they would be in danger of losing Henrietta, and in fear of such a loss they arranged for the immediate adoption of both children.\* Ties of affection were never established for Bertha in this home. Mrs. C. soon realized that she had undertaken a heavy task in adopting Bertha. As her affection for Henrietta grew she pushed Bertha farther and farther out of the family circle. Bertha lived a rather solitary life in this home for two years, when to the relief of all concerned Mrs. A. telephoned to ask if Bertha might visit them. This contact opened the way for further visits. The occasional visits to her former home where she was really cared for made the C. home seem to Bertha cold and unfeeling, and she spoke openly of her affection for Mr. and Mrs. A.

\* In Illinois there need be no waiting period before final legal adoption papers may be signed in court. In the absence of a law covering this, the better child placing agencies usually retain custody for a probationary period. See Elinor Nims, *The Illinois Adoption Law and Its Administration* (University of Chicago Press, Chicago, 1928).

About this same time two events of importance occurred simultaneously. Mrs. C. discovered Bertha's habit of frequent masturbation, and a neighbor, noticing the different types of care given to the two sisters, complained to a children's protective agency that Bertha was being neglected. A worker from the agency visited the home, learned much of the history from Mrs. C., and advised consulting the Institute. It was through the leadership of this agency that Bertha came to the attention of the Institute.

At the Institute it was noted that Mrs. C. was a well-dressed, self-assured woman, positive in her viewpoints. She admitted readily that she and her husband had taken Bertha only because they feared that otherwise they might lose Henrietta. They were neutral in their feeling toward her at first, but had gradually come to regard her as an intruder. The discovery of the masturbation was "the last straw" and they both now felt the child to be repulsive. They had tried to control the masturbation by constant checking up on the child, by inquiring every time she came from the bathroom whether she "had been bad," and by tying her hands at night. Because of this her wrists were constantly swollen, but "what was one to do?"

The school reported the child as "solemn and melancholy, rarely smiling or laughing; very polite, as though she had been drilled; *too* inoffensive." The school reported furthermore that in her academic work she answered questions intelligently, but was inattentive, often putting her head down on her desk. She was listed as doing well in everything but reading. Teachers had noticed that her wrists were "horribly swollen."

Bertha, in the examination situations, was spontaneous and cordial though a bit restless. The physical examination revealed that the hygiene of the genitalia was poor and that there was slight inflammation of these parts, a finding prob-

ably partly a cause and partly a result of her masturbation. Hygienic care and treatment of the genitalia were advised. On the Stanford-Binet Scale she achieved a mental age of seven years, nine months, which divided by her chronological age of six years, seven months, yielded an intelligence quotient of 121, classifying her as one of superior intelligence. The psychologist further discovered that she had a marked reading disability, and for this tutoring was advised. The psychiatrist found the child preserved a vivid remembrance of her early sex experience in the boarding home and felt extremely guilty about this and her masturbation. The staff recognized that the relationships in the C.'s home were too strained to permit any real adjustment to be made there and advised the protective agency to look into the possibility and advisability of returning Bertha to her former home in the A. family. Apparently something went wrong, for Mrs. C. suddenly broke off all contact with agencies and refused to bring Bertha to the clinic for the tutoring in reading which had been offered her. This break was associated with a fear of interference by the State agent, for when next heard from, eight months later, Bertha had been returned to Mrs. A., and, in secret, new adoption papers had been consummated. Mrs. A. brought Bertha to the clinic to report that she now "had custody" and had arranged for tutoring and medical care to diminish the irritation of the vulva and that in consequence, "Bertha was a changed girl." Both she and Bertha expressed satisfaction at being together again, although Bertha made one rather wistful allusion to her separation from Henrietta.

Our contact with Bertha ended at this point, leaving one with the pleasing impression of a happy adjustment and hopeful future for her. Those experienced in child guidance know, however, that the return to the A. family could not

of itself wipe out the impress made by all of the insecurity and trauma which Bertha had already experienced.

**Discussion.** Although life very often presents almost overwhelmingly perplexing problems to children of broken homes, it is also well known that careful agency work in planning and bolstering foster homes may do much to mitigate the otherwise uncertain lot of these children. There are many remarkably successful examples of child placement, but these, just because of their success, are not likely to appear at the doors of a child guidance clinic. An occasional case does come, perhaps for vocational guidance, perhaps because the foster parents merely want reassurance as to their *modus operandi*.

Such a case is that of a girl of six years, at the time of study at the clinic, who had been adopted when six months old by a childless couple. The foster father was a physician, and the foster mother socially prominent and a club leader. The child had been adopted after long and very thorough search on the part of the foster parents. They secured the child through friends who had accidentally heard that the child's parents had suddenly died during an epidemic. The child was, from the first, welcomed, and one of the earliest stories which the child begged to have repeated was about "how you found me and picked me out from all the babies you might have taken home." This child was of adequate intelligence, was placed in a superior home, and had known none of the uncertainties of multiple placements, which are the lot of many orphan children. The prognosis for continued good adjustment seemed in this case as good as that of any child in an excellent and suitable home.

In general, however, it may be said that successful placements are made by child placing agencies without help from the clinic set-up, except for diagnostic purposes. The failures, on the other hand, are brought to the clinic doors for



help. Often the clinic sees in these cases such a complicated network of social and individual problems that its staff is frequently baffled in the attempt to determine wherein lies cause and effect in the total picture. Clinic staffs have been asked to evaluate many homes which are patently inadequate to furnish the children therein with a full, free, and happy life. These same examiners have learned through experience in many cases that the recommendation "foster home placement" does not necessarily afford any guarantee that the ideal picture of happiness and security in a new setting can be attained. There are many cases in which removal from a home has been followed by kaleidoscopic changes, a series of receiving homes, temporary homes, placements often made with high hopes of success but ending in failure, gaps between placements, and placements too hurriedly made. Children are often removed from an inadequate home in childhood, placed in a new setting over a period of years, only to have to return to this same inadequate home in the impressionable years of late adolescence when childhood is considered over, and the time for earning one's living approaches. All these things can happen in spite of the fact that for the orphaned child or the child of a broken home there exist in most large communities child placing agencies of high excellence.

In most communities side by side with the best agencies, there usually exist small struggling agencies devoted to caring for children, many staffed by persons with good will and the best intentions but without the trained leadership that might give direction to their work. These agencies often handle a relatively large proportion of the total dependent child population but they do it in a rather inadequate fashion. The better, more progressive agencies undertake intensive and excellent work with fewer children. Other placements are handled by individuals or are arranged by



the so-called "baby farms"—organizations existing outside the law and for the profit which may be secured from "lump sum settlements" with unfortunate women in relieving them of the care of unwanted offspring. This sum is often supplemented by charging a fee to the foster family receiving the child.

The child from the broken home may pass through any of these agencies and may be brought to the clinic at any stage in the process of locating and settling him in a new home. Much of the success of treatment depends on how early this planning is done, what community agencies give aid, and what legal protection of the child the State itself offers.

### Bennie •

The father of eight-year-old Bennie referred him to the child guidance clinic "because the boy is so wild he is driving my wife insane and I got to do something." According to the father, Bennie was selfish and cruel to other children. He was impudent and "lazy" in school and considered the poorest student in the second-grade class. At home he exhibited violent spells of temper during which he would kick, hit, or bite any one who came his way. He thrust himself violently forward for attention. When there were callers he would hurl himself on them, and insist that they talk with him.

The clinic examiners found Bennie to be a rather attractive boy, in good health and of average intelligence. The study of the family situation soon revealed the fundamental cause of the difficulty. Bennie's mother was a tense, fearful, high-strung little woman, who, as a girl, had suffered from attacks of chorea and had been considered nervous. When Bennie was a year old his mother's sister had committed suicide. Shortly afterward the mother suffered a "mental

breakdown" characterized by hallucinations and by delusions of persecution. She was placed in a State hospital where her illness was diagnosed as dementia præcox. A year later she had seemingly recovered and had returned home. A certain degree of mental instability still persisted and took the form of worries and fears which no amount of reasoning or reassurance could dispel. She was afraid that her illness might have some effect on Bennie. Because of this she waited on him hand and foot and catered to his every whim. When his father, who was a slow, hard-working, and rather dull man, protested, the mother went to pieces and had long crying spells. At such times she accused the father of hating the boy. Because she was afraid that Bennie would get hurt if he played out of doors, she kept him in the house with her.

At the time Bennie started in school he had had very little experience in playing with other children. He was used to having his own way and so when he did not get it he fought. When complaints began to come in from the school in regard to Bennie's behavior, the mother decided something should be done. First she pleaded with him, then she threatened him. Finally the father whipped him severely. None of these methods brought any lasting improvement. One day the mother heard another boy call Bennie "screw loose." This gave her the idea that the neighbors thought Bennie crazy. To her it seemed that they must think him crazy because they knew that she once had been in a State hospital. The father's efforts to reassure her were futile. By the time Bennie was brought to the clinic, the mother's condition, as well as Bennie's, was serious. While she was able to keep up her home and do the housework, she refused to go out because she thought the neighbors would talk about her and say what a bad mother she was to Bennie. She continued alternately to threaten and plead with Bennie, and to indulge and wait on him.

It was the opinion of the clinic staff that immediate removal of the boy from home was indicated. In this way it was hoped to fend off another acute mental breakdown on the part of the mother and to provide for the best interests of the boy himself. Both parents were anxious to see him placed elsewhere. The clinic social worker arranged for Bennie's admission to a children's institution, where he was added to a small group of boys in a cottage with house parents in charge. It was not long before he was taking part in the activities of the group and showing some interest in his school work. In four months he was reported to be a "good citizen who did his share of the cottage work and got along well with the other boys."

In the meantime the clinic social worker kept in touch with the parents. The first month the mother felt "blue" and lonely, but found comfort in the fact that she was "acting for the boy's good." The second month she showed resentment toward the worker and said, "I don't see why Bennie has to be away. He has a home and he's not an orphan." By the third month she blamed the father for sending the boy away. In a confidential tone she told the worker that the father had always plotted to get the boy out of the house. At the beginning of the fourth month, the father phoned the worker and said that he couldn't stand it any longer. The mother was insisting that Bennie return home. She refused to eat or to speak to the father. When the door bell rang she would hide, because she didn't want any one to see an awful mother who would let her child be "put away." Attempts to secure psychiatric help for the mother failed, as she flatly refused to talk to a doctor, and even grew suspicious of the worker.

The worker attempted a compromise and arranged for Bennie to spend his Christmas vacation at home. The boy's improvement, his need for further training, and the fact that

the mother was really ill and in no condition to make decisions, were all discussed with the father. He was utterly unable to cope with the situation. Two days before Bennie's holiday was to begin the father went to the institution and took the boy home. The parents were defiant and expected a scolding. The worker expressed a hope that they would carry out the suggestions for training given them by the cottage mother at the institution and invited them to call her if they wished further clinic service. Six weeks later the father phoned to report that Bennie was again having trouble in school. At first he "had been just fine at home." Soon, however, he "had begun to act up." After the first few weeks the mother had gone back to her alternate over-indulging and severe disciplining of the boy. When the worker called to see her a few days later the mother was very much upset and announced that she couldn't stand to have the boy around as he was a constant reminder of her failure as a mother. He would have to be placed elsewhere.

**Discussion.** The case is typical of many that come to the child guidance clinic where the problems grow out of the inadequacy of the parents. In this case, the mother, while not committable to an institution for the mentally ill, was so unstable that it was impossible for her to give her child adequate care. The striking change in his behavior once he was placed away from the mother confirmed the opinion of the clinic staff that her inconsistent methods of training and discipline were in a large part responsible for his unacceptable behavior. The father was not able to accept the mother's behavior as a part of her illness and tried in every way to meet her wishes even when this involved sacrifice of the child's welfare. In this case it seems futile to hope for a change in the mother's handling of the child. Unless some arrangement for long time placement of the boy can be worked out, his poor adjustment will in all probability con-

tinue. In the meantime the clinic social worker will keep in touch with the family. She will do what she can to assist the parents in meeting critical difficulties as they arise and she will endeavor to interpret the mother's behavior to the father in terms of her illness.

### Molly D.

In some instances the inadequacy of parents may be due to defective intelligence. This was true in the case of the D. family.

Mrs. D. brought nine-year-old Molly and eight-year-old Tommy to the child guidance clinic at the suggestion of the pediatric clinic where they were enrolled. She complained that they "were fresh and answered back," often played truant from school, and wouldn't mind her.

The clinic study showed both children to be undernourished. Molly had average intelligence, while Tommy was rated as dull. Molly was more articulate than Tommy and told the psychiatrist she was "sick of all the hollering at home." It was always noisy and dirty, she said, and she never had a clean dress to wear to school. The children made fun of her and she "hated it." Sometime later, Roy, the five-year-old, was examined and found to be of borderline intelligence. The youngest child, Ella, then three, was not seen at the clinic, but so far as the social worker could observe she seemed to be at least average in intelligence.

The clinic social worker visited the home in order to get better acquainted with the family and found the house in a chaotic state. Everywhere there were signs of the mother's inadequacy as a home maker: soiled clothing, unwashed dishes, and unmade beds. If the children were noisy the mother screamed at them. When they didn't hush, she darted after them, shouting, "I'll kill you if you don't shut up." Meals were casual affairs. Often the children were permitted



to choose their own food at the neighborhood store. Pie, pickles, and bologna figured largely in their purchases.

The worker learned that neither parent had gone beyond the fourth grade in school. The father had dropped out and had gone to work on a farm. The mother stayed in school until she "got so big she was ashamed," then she too had dropped out. The father was a day laborer and earned a living wage. A large portion of his earnings went for first payments on radios, living room sets, and so forth, which the collectors were continually removing from the home because he "would kind of lose interest" after two or three payments. The father whipped the children severely, even for trivial offenses. He discussed this freely, saying, "I don't go to hit them, but when they holler I get sore and I got to hit out, because that's my nature."

For two years the clinic social worker kept in close touch with the family. The children were sent to summer camps and enrolled in settlement house clubs. They responded eagerly and enjoyed camp and club life. At first the worker tried to discuss methods of child training and household management with the mother. Nothing was accomplished. Because the staff recognized that the problems of the children were a direct outgrowth of the mismanagement at home, an experimental program was decided upon. The social worker, who was a student with considerable free time at her disposal, spent a great deal of it with the mother, helping her to plan and execute her housework and discussing with her the handling of concrete and immediate situations that arose with the children. Both parents enjoyed the worker's visits. They looked on the worker as their "big sister" and they cried when she finally left the city. However, so far as any lasting results were concerned, this treatment seemed ineffectual. Once the worker was out of the house the mother

slipped back into her old ways even though she had attempted to change them during the worker's visits.

The mother was in constant fear of pregnancy and childbirth and begged for contraceptive advice. When it was given her by a medical clinic through another social agency, she did not follow it and said that the father objected.

A fifth child was born and a visiting housekeeper was secured to care for the house during the mother's confinement. In a few days the house was clean and the children tidy. They arrived at school on time and were served regular meals. After a week the father dismissed the housekeeper because "she makes me nervous, always picking up and cleaning." With each new emergency, from the baby's colic to the father's loss of his job, the parents called on the clinic. The staff decided to try to secure psychiatric and psychological examinations of the parents. Both seemed very dull, and the worker felt the need of a diagnosis of their capabilities so that she might be guided more intelligently in working with them. Both parents were furious and stayed "mad" at the worker for some time. They refused to submit to the examination.

At the end of the two-year period the father was unemployed and a relief agency was aiding the family. The children's problems remained the same. At that time it was decided that the clinic would withdraw from the case. The relief agency agreed to keep in touch with the children and to encourage their contacts with groups outside the home. The clinic staff was of the opinion that any contacts with the parents, other than superficial ones connected with the practical matter of food and shelter, were futile. At this time the possibility of separating the children from the parents was considered and decided against. The parents would not have consented to such a plan, and it would have been diffi-

cult to prove in court that the children had been neglected.\* They were fond of their children and wanted to care for them, but, because they were inadequate themselves, they were incapable of filling adequately the rôle of parents.

**Discussion.** In cases such as the two just cited, the prognosis for successful adjustment is poor. Treatment of children in home situations such as these has already swelled the rolls of social agencies. The most important contribution the clinic can make is to help in clarifying the understanding of the underlying factors involved in each case. It is important to be able to recognize an untreatable situation. No amount of "reasoning" will rid Bennie's mother of her fears, and no amount of instruction will turn Mrs. D. into a competent mother. Early recognition of this will save much otherwise ill-directed effort on the part of the social agency.

It is also important to be able to judge when situations such as the above have become intolerable, and when, for the best interests of the child and the community, they should be referred to an agency such as the Juvenile Court, where protection for the children can be secured. If Bennie's mother had been influenced more strongly by her fears and had locked him in the closet in order to keep him away from the "spiteful neighbors," or, if Mrs. D. had allowed the children to go hungry, court action could readily have been secured. Yet, it is probable that such treatment would not have been any more harmful to the children than the somewhat less spectacular handling to which they are now subjected daily. As has been said elsewhere in this book, placement of a child away from his own home does not always prove successful. Even when parents seem woefully

\* According to Juvenile Court procedure it is necessary to present definite evidence, establishing the fact of a child's dependence, neglect, or delinquency, before court action can be taken to remove that child from the home against the wishes of his parents.

inadequate, the clinic is slow to recommend the removal of children from their own homes. In many cases similar to those just cited, the clinic must arrive at the decision that under the existing circumstances it has nothing further to offer or that it can only continue treatment of a superficial sort, all the while recognizing that the underlying cause of the maladjustment remains unchanged.

### Elizabeth

Elizabeth, age eight, and John, age eleven, were brought to the clinic by their mother who was told of the Institute by their school principal. The mother complained that Elizabeth was unmanageable, had frequent temper tantrums, and told numerous lies. Elizabeth embarrassed her in public by the use of rough language and defiance. On Armistice day the child had said, "I'm glad we're having a day off so that I can stay home and fight with you." When her mother called her for dinner she would stand in the yard and yell, "Oh, dry up!" She liked to quarrel about trivial things and frequently argued about something as ridiculous as "two plus two equals five."

The mother said, as is obvious from these examples, that Elizabeth enjoyed being contrary. When she told a neighbor that she had been housecleaning, Elizabeth interrupted and said, "Why, you were not housecleaning to-day!" She would not give in to any one and when not given her own way would go to her room and pull the bed clothes off the bed, tear up papers and toys and strew them around just "to get even." She frequently said to the mother, "I hate you!" She acted as though she had the same feeling for everyone. The mother was disturbed when she discovered Elizabeth and a girl friend playing hospital with their panties down, but she was afraid to give her any sex information because she thought she might "go around and tell everyone."



The mother had fewer complaints about John, who was more passive than his sister. His difficulties seemed largely an outgrowth of his relationship with Elizabeth, and when he thought she "was getting the best of him" he would scream and throw himself on the floor and kick. Sometimes, when not given his own way he would lie on the floor and whine. He was not allowed to hit his sister but feigned the motions of doing so many times. However, when she cried he felt sorry for her and put his arm around her, saying, "Never mind, sis, you know I love you."

The mother and father both took active rôles in the management of the children. After shouting at the children the father frequently let them do what they wished. He was consistent only in insisting that John give in to Elizabeth. She would say to her brother, "I'm a girl and Daddy won't let you hit me." The father thought she was "just fresh enough" and said he liked a girl to be a "little of a tomboy and a little sassy." The mother, though frequently blocked by the father in her attempt to punish the children, tried to be consistent. She used such methods as spankings and deprivation of pleasures. John always responded to a threat that he would be spanked, but Elizabeth was unperturbed and did as she pleased.

Elizabeth's behavior at school presented quite a contrast to her actions at home. She was in grade two B. Her teacher said that she was afraid to recite before the class, that she was slow, and that she had an "inferior complex." She did her work when allowed to sit quietly and alone. John, who was in grade six B, was described as the best in his class. He finished his work so quickly that the teacher had to send him on errands to keep him busy. The boys called him "sissy" and "teacher's pet." John resented this and complained to his mother that his grades, which averaged ninety, were "too good."



The mother gave the picture of a rather comfortable home. The family lived in a six-room apartment with two baths and a sleeping porch. There had been frequent moves because as the economic situation improved the mother was anxious to have "everything as nice as possible." The father was president of a plumbing supply company and there was a minimum income of \$325.00 a month. This enabled them to have a maid as well as some luxuries. The father came home from work about six-thirty in the evening. The family spent many evenings at home, reading.

Both the mother and father were of Bohemian parentage and the mother, particularly, had lived under close restrictions while living with her parents. Although she was born in Chicago, her family was largely dominated by old-world customs. Her father did not believe in giving girls an education and she did not advance beyond the eighth grade. She described the maternal grandmother as an "old-country" type who believed "whatever Dad said was right." She seemed very much aware of her lack of educational background and floundered considerably when discussing general topics. She would start a sentence, then stop in the middle and say, "You know—it's kind of—you know." Her appearance, however, was that of a cultured woman.

The father, one of six brothers, was the son of a "sober bartender." He finished the eighth grade and began work as a messenger boy at the age of fourteen. While working he took a high school course at night. He later became an accountant. Several years after his marriage he and his brother organized a plumbing supply company. He had charge of the office, while his brother assumed responsibility for the factory. This venture was successful, and they managed to weather the depression. The father, who was a tall, heavy-set man, was described by the mother as "nervous" and one

who could never "take things easily." He tried to "shake worries but just couldn't."

The mother met the father when she was seventeen and he was twenty. She was attracted to him because he was "clean cut" and not "fresh." "He had only gone with one girl before and was not in the habit of being smart with girls." They were married after an acquaintance of two years. She described their relationship as a rather unhappy one although they were alike in their interests. They both liked art "though we don't understand it." They enjoyed driving in the country. Their chief form of recreation, however, was playing bridge with friends.

At the time of their marriage the father was an accountant, and it was not until ten years prior to their coming to the clinic that they prospered financially. Before this the mother worked as an elevator operator in the afternoon and took care of the maternal grandmother's home as well as her own. This arrangement continued until the grandmother's death, which occurred when the mother was five months pregnant with John.

The mother, though she had been married three years, regretted her pregnancy. She and her husband both felt that they were not ready to have children because of the grandmother's illness, but after her death they were glad to look forward to the coming of a baby. The father was eager for a girl and the mother for a boy. When John was born the mother was so delighted in him that she hoped her second child would be a boy. The father, on the contrary, showed little interest and said he regretted that John was not a girl "because he had never had a sister." Consequently when Elizabeth came he was "partial to her from the beginning."

The mother was unable to nurse either of the children except for a few weeks after their birth. There were some feeding difficulties during the early years of each and at the

time of examination at the clinic they were described as having poor appetites. The physical examination, however, revealed nothing significant except that both children were thin and poorly nourished.

Elizabeth refused to coöperate with the psychologist and remained sullen throughout her interview with him. She was slow to respond and her answers were brief. Her general intelligence was therefore not rated, but in performance she was found to have ability slightly below average. John was described by the psychologist as being friendly and attentive and as giving full coöperation during the mental test. His answers were quick but reflective. With a chronological age of eleven years and one month he was found to have a mental age of twelve years and five months, which classified him as having superior intelligence.

The psychiatrist described Elizabeth as a "very complacent little girl who seemed entirely satisfied with herself and her relations with her brother." She said her brother was a "mean boy" but she could get him into trouble whenever she wished. She told how she succeeded in getting him whipped the morning of the interview. She could slap him but he couldn't hit back. She was quite sure that she was the favorite child of both parents and was doubtful that either her mother or father liked John. She said that she had both girl and boy friends and that she had more of the latter than she knew what to do with. She told the psychiatrist that she did not like school.

The psychiatric interview with John revealed a friendly boy who made an excellent adjustment to other children but was greatly provoked by his sister whom he regarded as a "pest." Although he spoke of a girl friend he said he disapproved of girls and women in general. Of his sister he said, "Girls can't fight, but they certainly can get boys into trouble." He evinced a fair amount of interest in school but said

his chief goal in life was to be a professional baseball player. He spent much time reading the sports section of the daily paper and displayed an interest in all sports.

At the time of the initial examinations the psychiatrist talked with both parents, though the father was seen but briefly. He presented the picture of an aggressive person who lacked self-confidence. He said that he was not particularly worried about the children "though they quarrelled a great deal."

The mother, when interviewed, evinced more interest in receiving help than did the father. She said that she was not worried about John, but was very much concerned because her husband persisted in spoiling Elizabeth. She said he loved to dream and plan for her future. When she grew older he hoped to have a great deal of money to spend on her and to be able to dress her in the height of fashion. He also hoped that she would have many admirers, but that she would never marry. The mere thought of her marriage appeared to be almost enough to provoke anger in him. The mother seemed to recognize the fact that Elizabeth had no regard for the ordinary rules of fair play. She thought that the children's difficulties were aggravated by the father's behavior in the home and described him as one who had an ungovernable temper and frequently used violent and obscene language. She said that if she happened to have boiled eggs for breakfast on a morning when he wanted fried eggs he stormed and raved, but a few moments later was tender and loving. One time he punished John for using an obscene term which he himself used almost every day. The mother called his attention to this but he was unimpressed.

When the psychiatrist pointed out to the mother that Elizabeth seemed somewhat disturbed because she did not know where babies came from, she said that she had not



given the children any sex instruction because she did not know how.

She said that as a child she was brought up with such a guilty attitude toward sex that she still felt ashamed of her body. She implied that this attitude interfered with her marital life, and that because of this she has tried to rear the children differently. When they were small she let them bathe together and share the same room, but she felt totally unequipped to give them any facts about sex. When John asked her how it happened that movie actresses married frequently but had no children she evaded the question.

**Discussion.** After the entire family was interviewed it was felt by the staff that the children's problem could best be treated through an approach to the parents, for obviously they were at the basis of the difficulty. Here was an instance in which the daughter was the favorite of the father and the son of the mother. The children were reacting in a rather normal way to the situation in which they found themselves. The mother, however, was not as naïve as her husband in regard to parental duty and did not come as wholeheartedly to John's defense as did the father to Elizabeth's. The mother even had some uneasiness about her partiality for John which led her at times to be over-severe with him and to back Elizabeth unjustly. In the quarrels between the children Elizabeth was therefore more successfully backed up than was John, particularly since the father was more dominating and aggressive than the mother.

It was evident from the history that both parents were quite immature when they were married and unprepared for the personality adjustment which marriage entails. The result was that their married life was largely a series of quarrels and disagreements, although they were basically very fond of each other. Their difficulty in adjustment was complicated by the fact that the mother had had a very



repressive upbringing and felt that sexual relations were shameful. In consequence their sexual adjustment was poor. Since neither parent obtained much emotional satisfaction from the other, they began to drift apart. Both parents had a large capacity for devotion and for interest, and, since their quarrels and misunderstandings prevented their exercising this capacity with respect to each other, it found other channels. The children were at hand and the result was not surprising. The mother began to center her interests and attention in John and the father became even more completely wrapped up in Elizabeth. The misunderstandings between the parents were carried over into the quarrels between the children.

Besides these emotional problems, it was evident that other factors contributed to the unhappiness in the home situation. The mother felt intellectually inferior to the father because he had had more academic training than she. John was considerably brighter than Elizabeth, who undoubtedly sensed her inferiority. Since she could not compete with him intellectually, she no doubt tried to compensate by gaining attention in other ways.

In bringing about a better relationship between the parents it was hoped that the children might be affected and at least part of their problems solved. Ideally, both parents should have returned to the Institute for psychiatric treatment. This was impossible because the father was unwilling. Since the mother was eager for help, she was invited to come back and talk over her own difficulties as well as those she was having with the children. Besides this, some concrete suggestions were made to the parents concerning the handling of immediate problems. It was suggested that an attempt be made to improve the children's nutrition by

supplying them with a high caloric diet. It was suggested that the mother read *Growing Up* by Karl de Schweinitz with the idea that this book might help her in giving sex information to Elizabeth and that the book also be given to John to read. An attempt was made to present to the parents a rather clear picture of Elizabeth's conception of her rôle in the family, with a view to stimulating them to change some of their attitudes. It was also suggested that the children be given separate rooms, which each was not to enter except by invitation of the owner and that whenever possible they be allowed to settle their own difficulties between themselves. Separate camp placements for the children for the summer were also advised.

Two weeks after the initial examination the mother and children returned to the psychiatrist. The mother said that she saw some improvement in the attitudes of the children toward each other although they continued to quarrel about trivial matters. Elizabeth had been ill and this caused some concern on the part of John. He said he did not like her to look pale. When Elizabeth announced that one of her friends had a pretty face but that she had a pretty figure, John said, "You have a cute face." They had also gone to the movies together, something they had not done before.

The parents and John had read *Growing Up* with interest. In commenting on the book the father wondered what his mother would say if she knew the children were allowed to read such literature. In discussing this the mother was prompted to tell of some of her attitudes about sex. She said that as a child she was taught that anything of a sexual nature was "unspeakably vile." When she was Elizabeth's age and was attending a Ladies' Aid meeting with her mother some reference was made to an unmarried girl who had a baby. She spoke up and said, "Well, how could she have a baby if she wasn't married?" Her mother became very angry

and immediately took her into the bathroom where she slapped her and said, "Who's been talking to you? Who's put such ideas in your head?" This created a deep impression on her although at the time the girl was confused as to why she was being punished.

She said she used to feel that sexual relations were "low in some way" and that at times during coitus she would murmur to herself, "filthy, filthy." Her husband argued that physical union was an expression of love, but she would not be convinced, nor was she helped to enter more fully into her relationship with him when he told her that she was perfect except for this one inability. She said that gradually she was beginning to see that her previous attitudes were wrong and that sexual experiences might be satisfying. When the psychiatrist reassured her in this point of view she seemed relieved. She asked if she might return to the clinic for further interviews.

The children were seen briefly on the same day. In the interim the mother had acted upon the concrete suggestions that had been given her. Elizabeth complained at this time that she no longer could get John into trouble. She said, "He gets me into trouble now." John seemed to feel that he was being treated more fairly in the home, but remarked that he still had trouble with his sister.

During the next two months the mother made several visits to the clinic unaccompanied by the children, and during the interviews with the psychiatrist talked primarily of her own problems and her relationship to her husband. She spoke freely of her quarrels and difficulties with him, of his ungovernable temper and the subterfuges she found necessary to resort to, in order to keep things running at all smoothly in the home. Previously she had never really examined her husband's temper and what it did to her. She had been filled with annoyance and bitterness by it, but

this was always accompanied by a sense of guilt, because, in her immaturity, she had felt that it was wrong to feel any critical attitude toward her husband. When she talked freely about her difficulties with him, she understood more clearly the nature of his reactions, recognized his immaturity, and in a frank yet reasonable way worked out schemes for getting along with him with the least possible friction. Furthermore, she recognized clearly that in spite of her annoyance and difficulties, her essential attitude toward him was one of affection. The mother after several interviews reported that, although she and her husband were somewhat happier in their relationship, his temper continued to be a disturbing factor in the home and he still spoiled Elizabeth. She said, "John has a regular allowance but I couldn't give Elizabeth one because she would spend it all in a day and then get more money from her father. One moment he spoils her and the next moment he punishes her severely." The mother had observed some improvement on his part and said that on several occasions he had commended her when she was successful in handling a disciplinary problem. She said that she had no further problems to discuss and saw no need for further contact with the clinic.

After a lapse of several months the mother phoned and asked if she might return, presumably to talk about Elizabeth's school placement. However, when she saw the psychiatrist she was not so much concerned with Elizabeth as with her husband's behavior. She said that in spite of the fact that she considered their sexual adjustment satisfactory she found him a difficult person with whom to live. "He always wants to get places on time, makes a terrible fuss about it, and yet is always late." The mother thought he was unfair about money matters. Several weeks before, he told her they would have to economize and the next day bought John a sixteen dollar tennis racket. The father resented her



expenditures, but bought the children anything they requested. She stated that when they went out socially he catered to all types of people and everyone thought he was a wonderful man. He criticized her for her stiffness and resented the fact that she would not allow his friends to kiss her, which they occasionally tried to do when they had had too much to drink. "He is high-spirited when he is away from home but becomes ill-tempered the minute he returns." The mother thought his behavior indicated a need for psychiatric treatment and she hoped to be able to persuade him to come to the Institute. She said, "He will never come for his own sake," but thought she might persuade him to come for the sake of Elizabeth. Her husband had evinced interest in some lectures on mental hygiene which they attended and had tried to carry out some of the suggestions made by the speaker about relaxation. This gave her hope that he might become interested in solving some of his own problems.

Whether the mother will be able to persuade the father to request treatment for himself and whether she will return to the clinic is doubtful. At the present time it is evident that the superficial adjustment which the parents have made to each other is reflected to some extent in their improved treatment of the children. The mother's intellectual grasp of the situation is helping her in dealing more wisely with the children's difficulties as they arise. However, it is unlikely that there will be a fundamental change in the family situation unless both parents receive psychotherapy over an extended period of time.

### Morris R.

Morris R., a two-and-one-half-year-old boy, had been attending nursery school for a week at the time of his examination at the Institute. His mother had placed him in the



nursery school so that she could look for employment. The nursery school staff observed that he was excessively dependent upon his mother; that he craved much attention from adults; and that he was stubborn, overactive, and easily distracted. Frequently he had outbursts of temper and crying. Other problems related to the nursery school routine were disinclination to eat and screaming at nap time.

An agency which had been interested in the family for two years supplemented the family income because the father was unable to find work and was not in good health. Mr. and Mrs. R. were above the average of the agency's clients culturally, and at first they were very independent and wished to consider the financial help merely as a loan, but after a time this attitude changed. It was obvious that it was difficult for them to adjust to a lower standard of living.

The history reported to the clinic by the family agency showed that the parents were inordinately proud of Morris; excessively devoted to him; unduly anxious about his eating; and fearful that he would lose weight if he were not allowed to have his bottle in the morning, at nap time, and at night. The parents stated to the agency worker that neither of them disputed the other's requests or demands upon Morris, but actually she observed disputes of this kind while visiting the home. She also noted that the parents made threats of punishment which they failed to carry out and that they used emotional appeals such as threatening not to love Morris if he were not a good boy. They stated that they used physical punishment very infrequently since they had found that on the occasions when this had been tried the child administered the same punishment to them. The mother told the agency worker that for some time before she placed Morris in the nursery school she had been having difficulty getting him to take an afternoon nap. He was fre-

quently very stubborn. He was afraid of dogs and of the dark. He even insisted that the light be kept on in the daytime, and his parents acquiesced, although they could ill afford this additional expense. He was very active and could not sit still. He tired quickly of any toy and then threw it on the floor and broke it. The parents reported that he quarreled with other children, but this, in the opinion of the father, was due to Morris' superiority. He loved to make speeches and would stand in the middle of a room and address his mother, "Ladies and Gentlemen," and give a long speech. He called the nursery school "college" and said that he was too old to attend a nursery school. If people did not applaud his tricks he became angry at them. One of his uncles paid little attention to him. Morris told his mother that he didn't like this uncle because he did not praise him for his tricks.

Mr. R., Morris' father, was born in Poland. After completing there the equivalent of the second year of high school in this country, he worked in his father's store. At the age of twenty-five years he came to the United States on the suggestion of his brother who had been here for a few years. When he arrived he was untrained for any type of industrial work, and it was necessary for him to take training before he could secure employment. He learned a skilled trade and worked at it for about fifteen years. For four years before the time of Morris' examination at the Institute, since Mr. R. was no longer able to find work in his trade, he had been working irregularly at various manual, unskilled jobs.

For some years after coming to this country, Mr. R. was interested in the violin and had wished to prepare himself to play in an orchestra. Mrs. R., too, had a special interest in music.

Mrs. R. was two years younger than her husband and was born in Germany. She attended the gymnasium there

but did not finish. However, she had the equivalent of two years of high school work and because Jewish women were not permitted to teach in the schools she prepared children for school by private tutoring. Mrs. R. came to the United States at the age of twenty-six and obtained work in a factory. She tried to save money so she could bring her family to this country. About a year after she had come to the States she met Mr. R. at a recital. They were married a few years later. At first both of them continued to work in order to save as much money as possible, for they had formed a plan to finish their musical educations in Italy. A few months after marriage, however, Mrs. R. had a miscarriage and was very ill. She did not return to work for several years. After that she worked as a milliner's assistant for about four years and it was during the latter part of this period that she became pregnant with Morris.

At the time of Morris' birth his father was forty years old and his mother thirty-eight; they had been married for nearly ten years. Labor was prolonged and difficult. From infancy, Morris had a poor appetite; he refused vegetables and cereals. When he was about a year and one half old his mother placed him in a day nursery intending to keep him there so she could be employed. He cried all the first day and would not eat. According to her account the doctor at the day nursery told her that Morris was a very sensitive child, that he needed her very much, and that she should not neglect him or permit him to be away from her. Morris stayed at the nursery just one day.

The parents stinted themselves so that the child could have the kinds of food he would eat. Whereas they ate eggs once a week, Morris had them daily. The parents had fruit once a week, the child daily. Lamb chops, spring chicken, and other more expensive foods were bought solely for him and to tempt his appetite. The parents used various means

to get him to eat; they coaxed, nagged, scolded, told stories to him, and searched for his favorite toys so that he could have them at the table with him.

When the social worker from the Institute talked with Mrs. R. the first time, she recorded the following impression: "Mrs. R. seems intelligent but strangely lacking in common sense. She appears to be on the defensive with respect to the methods she is using in dealing with Morris and is so emotionally wrapped up in him and has so rationalized her attitudes and conduct toward him that it will be very difficult to get her to change. She questions the patient's need for examination, saying that she was under the impression that the Institute examined only 'difficult children.'"

The physical examination given Morris by the agency physician revealed rickets and malnutrition. Ultra violet light treatments, diet control, and cod liver oil were recommended.

An intelligence test administered at the time of Morris' examination at the Institute indicated that he had superior intelligence. During the examination he was very restless and very talkative and showed a lack of persistence in the face of any difficulty. He was observed to be quick and careful in his movements and his language development was unusually good for his age.

The psychiatrist observed Morris for a short time at the nursery school. He found the child very alert, spoiled, dependent, and demanding. Then the psychiatrist had an interview with Mrs. R. He gained about the same impression of her as had the social worker. She gave indications of a tendency to minimize Morris' problems and to accept his behavior much more tolerantly and indulgently than the average mother would have done. She was also inclined to cover up or to rationalize any of her methods which she



sensed might not be in agreement with accepted standards of child guidance.

The fountain-head of Morris' problems was, of course, his parents' attitude toward him. Their reaction was typical of that seen in numbers of middle-aged parents of only children who have long wanted a child and were not able to have one for a number of years after marriage. It is also observed frequently in parents who have been thwarted in their own ambitions and have centered all hopes in their child. In Morris' case the devotion to the child seemed even to go beyond that generally shown by such parents.

It appeared advisable, for the child's sake, to get the mother interested in something besides Morris and to help both parents to acquire a more objective attitude toward him. Several lines of attack upon the problem were outlined following the first examination. The mother was to be reassured about his health and to be assisted in developing better guidance methods. An effort was made to get the parents to attend the parents' meeting at the nursery school, to aid them in recognizing the aims of the nursery school. The mother was to be aided in obtaining employment and in cultivating outside interests, and the parents led gradually to a more objective and far-seeing attitude toward the child. They must be brought to understand how much more effective the child would be in all his achievements if he could become more independent.

Four months later, shortly before the end of the nursery school year, the case was reviewed. The nursery school staff reported that Morris had shown marked improvement in his general behavior. The parents were coöperating well with the school. During these four months the mother had been employed and was enjoying her work. The agency worker thought that Mrs. R. had a somewhat less emotional attitude toward Morris but that "she still has a long way to go."



Morris' physical condition had improved, he was gaining weight and the mother seemed no longer so worried about his health, but she was still anxious about the amount of food he ate. The Institute psychiatrist felt from the interviews he had with the parents that they were making some progress toward a more objective, long-range view of Morris and that their way of handling him had improved. Both parents apparently saw the relationship between their own personal disappointments and the excessive devotion with which they had surrounded Morris. Both spoke of their desire to help him to become self-reliant.

During the summer when Morris was at home and during the autumn, after the nursery school opened, Mrs. R. was given a number of appointments with the psychiatrist, none of which she kept. She did not come to see him until the nursery school was again having difficulty with Morris, and she had once more become disturbed about his health. Morris was causing a disturbance during the school nap periods. Following a brief illness, he was eating less at home and the mother had become anxious over the state of his nutrition. The psychiatrist tried again to impress upon her the poor results which follow a show of great solicitude about functions such as eating and sleeping which, if not influenced by external forces, are the spontaneous expression of the needs of the child.

During the following spring, Morris became fairly well adjusted at nursery school until shortly before the end of the year, when he began to use vulgar and obscene language, picked up from some children who lived next door. He sometimes threatened children at nursery school, using the various malign expressions he had heard from the neighbor children, such as "I'll blind you." The children at nursery school were beginning to dislike him. It was observed that Morris enjoyed the disturbance he was causing by these uses of bad

language and threats. Another factor which may have contributed to his using threats of injury was his mother's practice of telling him she would give him away if he were a bad boy. This threat she linked up in the child's mind with the idea of lost or kidnapped children. The psychiatrist had a conversation with her at this time, cautioning her against showing great concern over Morris' naughty talk and against threatening to leave him. Also since he was beginning to show some interest in sex, she was given some suggestions for the type of sex information to give him.

During the summer the social worker arranged to call at Morris' home to take him, together with several other children, on a picnic and trip to the zoo. The day before the picnic the mother telephoned the worker to ask if Mr. R. could go to the picnic, too, since Morris refused to go without one of his parents. She said Morris had been crying all the morning about it. The worker refused this permission, and when she called for him he went with her without a protest. He behaved quite well at the park, showed no fears, and even went so far as to put his fingers through the bars of the cages in the zoo in order to pet the animals. He was delighted with his ride on a pony, took care of himself in the toilet, and altogether was quite independent. But when he arrived home and saw his father coming toward him he began to act silly, running around and climbing over the automobile. The father, in a weak fashion, pleaded with him to behave, "Please, Morris dear," but Morris paid absolutely no attention to him. Then the worker talked with the father who said that the nursery school had been of great help with Morris. Though he said also that he and his wife were following the suggestions of the Institute, the worker observed that their efforts were weak and ineffectual.

The next autumn, after his summer vacation at home, Morris again returned to the nursery school. His former

troublesome behavior at nap time recurred. The nursery school staff had "to start all over again with him." He showed defiance in persistently breaking rules. The nursery school worker found that the parents were siding with the child against the school and that they little knew how much they still indulged and protected him at home. The parents tended, also, to avoid letting Morris face any unpleasant consequences of misbehavior and promised him that they would intercede for him at nursery school. Mr. and Mrs. R. could never be induced to attend the parents' meetings at the school.

During the winter the situation remained as described. The Institute did not initiate further work on the case, since the staff thought it would be wiser to let the matter rest with the parents. The case was closed a few months later because no further contacts were solicited.

From the standpoint of modifying the emotional situation in this family little was accomplished by the clinic staff or the social workers in other agencies. Even had the staff found it feasible to undertake more intensive therapy, involving a definite approach to the emotional problems of the parents, there is a serious question of the degree to which they would have coöperated, since the examination was requested by the nursery school and not by the parents themselves.

**Discussion.** In this case one can see clearly the operation and results of the excessive devotion of parents to their ideas regarding the necessary care of their child. They could not bear to see him suffer even the mild natural consequences of his misbehavior. They found it necessary to comfort him even when their comforting could only interfere with the growth of his ability to face reality courageously.

Some of the methods may have been the expression of blundering inexperience; other practices they may have bor-

rowed from the ways of others with children; but their choice of patterns was largely determined, as it is with other parents, by the underlying attitudes, both conscious and unconscious, which they had toward the child and by their own set of values, interests, and ambitions. Their selection of techniques was, in other words, guided by their own personalities. The pattern was too consistent to be a result merely of haste, impatience, inadequate judgment, limited experience, or other similar factors contributing to the selection of faulty methods.

There were times when the parents improved in the handling of the child, when they accepted some constructive goal, tangible to them, which the nursery school held before them, a goal which they felt they must reach so that their child could continue at the nursery school. In less tangible things they changed little. It was observed that the summer vacation period, which allowed more continuous contact between the child and his parents, again restored his problems to their previous flourishing state.

The parents spoke of their desire to teach Morris to be more self-reliant and of their desire to see him fit well into the group. They listened, apparently with attention, when advice was given, and they even seemed to have a belief that they were following the advice rather faithfully. Yet it is very doubtful whether they ever had any emotional appreciation of the extent of his objectionable behavior. They tended rather to accept it as the normal thing, even looking on some of his misbehavior as attractive and as an evidence of promise. The result was that they continued, perhaps unconsciously, to cultivate in him the reactions which others saw as troublesome, destructive, and needless.

What, then, are average, ordinary, usual attitudes of parents toward their children? Before answering this question it should be noted that it does not follow that usual attitudes



are to be regarded as ideal, although they may be accepted as "normal."

The average parents look forward toward the coming of a child with some degree of pleasure, and they welcome his birth or at least accept it. They manifest some degree of love for the child. Probably the mother manifests much more during the child's infancy. Many fathers do not find the baby very attractive until it is "able to do something." The love for the child is, in many cases, somewhat balanced by the negative feelings occasioned by the inevitable irritations or the inevitable thwarting of some desires which accompany parenthood. Normally, however, there is more of love than hostility.

They desire the child to be successful in life and well accepted. They tend to feel identified with the child. Or they may feel that the child will surely be like themselves in many traits. They may believe they know how he will feel in various situations. They tend to attribute to him various points of sensitiveness, various aspirations and aversions which they themselves have. In some cases, and probably the larger number, there is not so much of an *a priori* judgment of identification as a generalization from the child to themselves, based upon some similarities to themselves which they observe as the child's personality unfolds. Their feeling of identification is tempered by some appreciation of the fact that no two people can possibly be totally alike and that their child has already shown some difference from them.

They have some tendency to idealize the child, to step up their rating of him in the direction of various excellencies. They have some feeling that the child represents them before the world, that they will be judged by his conduct and achievement. As their incarnation he reaffirms their worth or perhaps advertises their inadequacy.

They tend to turn toward the child to work out through



his achievements some of their own wishes which have been frustrated. They may do this with the assumption that he will desire the same things which they had desired so avidly and they may, from the viewpoint of the child, quite definitely overvalue some opportunities for achievement.

They try to protect the child from the kind of injury or suffering which they have felt and to provide him with some of the satisfactions they were denied.

They wish a pleasurable response from the child. They long to have him love them, be devoted to them. Some parents turn to him for cheap and casual amusement, obtaining it from him by getting him to show reactions to an assortment of stimuli. With most parents this is a transient phase and is definitely inhibited by their appreciation that they are building up undesirable habits of reaction. They enjoy somewhat their feeling of power, of influence to mold or to dominate.

They have some sense of obligation to the child, obligation to provide him with an education and with other needed opportunities. They have some feeling of ownership of the child and along with this some pride of ownership. They do not, as a rule, feel that they have absolute ownership of him and with it the right to do with him whatever they may wish. Their feeling of ownership is partially balanced by their acceptance of him as an individual who must finally, and at a not so far distant time, become more or less independent. They feel that the young child is very fragile, needs much attention; that he may develop a number of undesirable reactions, but that he will outgrow them; that he may, however, develop objectionable tendencies which require vigorous treatment. Usually they have some confidence in his ability to grow up well, but they may have misgivings about particular aspects of his future.

In general, the child comes into a warm, supportive, inter-

ested, expectant, somewhat anxious environment. On the average, there is probably somewhat more protection, solicitude, and indulgence than is best for the child; we see these especially during the first few years of the child's life. But there will not be grievous or prolonged error in the functioning of parents who are reasonably stable, objective, social-minded and far-seeing and who do not find their child of supreme significance to them.

Some parents, because of their own needs, their distorted sense of value of the very special significance of their child, are likely to have attitudes toward their child characterized by excesses in one direction or other.

### Tom

Tom's mother brought him to the clinic when he was ten years old. For many years she and her husband had been concerned about him, but they had not known where to take him to get help. Finally the parents learned of the clinic from an author of popular articles on pediatrics and child care, and the mother arranged for an examination.

It became evident during the first interview with the mother that both she and the father were very much disappointed in Tom. Of the four children in the family he was the only one who was causing any difficulty; the others, in fact, were doing exceptionally well.

In school Tom was "dumb." Although he tried hard to do well, he could not learn. His teacher had told him that his younger brother would get ahead of him in school. The parents, too, kept telling him that. Tom was the biggest boy in his class. The mother often said, "You'll have a mustache and crutches by the time you're through school." The taunt, apparently, had not helped.

Tom's brothers and playmates teased him about his poor school work. The parents had grown to feel that he was a

defective child and were finding it increasingly difficult to accept him as an equally important member of the family. In addition to his "dumbness" he was peculiar in other ways. He wet his pants every day. The resulting odor was offensive to members of his family, his classmates, and playmates. Punishment and deprivation of privileges had no effect in correcting his enuresis. He picked his nose, bit his nails, and masturbated.

At home he was quarrelsome and constantly into mischief of some sort. He was showing increasing hostility toward his older brother, who was very sociable, attractive, and intelligent. The parents were particularly proud of this son and boasted of his excellent school record and his popularity among his playmates. Although the other brother's conception antedated their marriage by three months and had precipitated it at a time when his parents were young and somewhat reluctant to marry, he was welcomed and loved. On the other hand, Tom, born a year and a half later, was unwanted. The parents were feeling increased economic stress, and already had as many responsibilities as they felt they could shoulder. They were not ready to share their love for their first baby with another child.

Tom was well aware that his brother had superior abilities and was the favored one. Even another brother two years younger was becoming a "threat" to him, since he was about to be promoted to Tom's grade. With the youngest child, a sister, Tom had a rather friendly relationship, but its value was not sufficient to compensate for the strained relationship with his parents and brothers.

The father was decidedly antagonistic toward Tom. He found fault with everything he did and frequently blamed him for the other boys' misdemeanors as well. He seldom allowed Tom to share the brothers' privileges. He frequently

made fun of him and did not conceal the fact that he considered him a nuisance.

The father had been reduced to taking work as a day laborer, with only seasonal employment. When employed he earned fifteen dollars a week. The mother worked in a large department store. After a strenuous day there, she returned home and did all the housework, laundry, and sewing for the entire family. With her heavy burden of responsibilities she had become increasingly irritable. Most of her anxieties and tensions were directed toward Tom, since he was the least attractive and least capable of her four children. She never praised him. In the presence of Tom and the social worker, she remarked, "Tom is a good boy." His face lighted up and he looked at her smilingly. "When he's asleep," she added. Tom went back to the playroom.

The mother apparently expected Tom to be found mentally defective and, if he were, intended to have him placed outside the home. The Stanford-Binet Intelligence Test revealed, however, that he was average in his general intelligence. According to his mental ability he should have been able to do satisfactory work in the third grade in which he was placed. Since he was doing poorly in spite of adequate mental capacity, he was given achievement tests. His arithmetical ability was average for grade three A. However, his abilities in reading and spelling were equivalent only to those of children in grade one A. The Monroe Diagnostic Reading Examination indicated that his reading ability was retarded three years below his mental age and two years below his ability in arithmetic.

All of Tom's reading errors were analyzed and compared with those made by normal first-grade readers, since his general reading ability was comparable to theirs. Since all children make mistakes in reading, a certain number of errors are expected at each level of reading achievement.



But Tom exceeded the expected number in several types of errors. He made more than the normal number of "consonant" errors, reading "ton" as "tom" and "cat" as "rat." He often added sounds and repeated words and phrases. He made frequent "reversal" errors. He read "dig" as "big." He reversed the sequence of letters also, as when he read "saw" as "was," and "not" as "ton." When isolated letters were presented to him on a card, he made errors in naming the reversible letters: "b," "d," "u," and "n." It was apparent that he had never been able to establish smoothly the dextral direction in reading. He did not know the phonetic sounds of letters, but when he heard them was able to remember them fairly well. Tom had difficulty in blending sounds in word-building, probably because of his limited experience in phonics. Apparently he had normal auditory acuity and fairly good ability in auditory discrimination.

The boy experienced difficulty in discriminating complex visual patterns, such as words, but was able to recognize small unit letters. He frequently omitted sounds and guessed at words after recognizing one or two letters in them. His vocabulary was limited and this, too, handicapped his progress in reading. Because of his lack of language facility, he frequently failed to comprehend the meaning of words he read and was unable to utilize context cues for recognizing difficult words.

The physical examination revealed that Tom was average in size and well developed. Aside from carious teeth, no defects were discovered. Dental care was recommended. Tom was right-handed, right-footed, and sighted with the right eye. There was no indication of original left-handedness.

The ophthalmological examination included the usual visual acuity tests for distant and for near vision. A thorough examination of the eyes was made, including testing of the external ocular muscles for deviations (tropias) or tenden-



cies to deviate (phorias). Tests were made of the degree of stereopsis and of ocular dominance. Although Tom had normal visual acuity, his refraction was determined after influence of "drops" in order to exclude any latent farsightedness (hyperopia) or accommodation spasm. None of the examinations revealed any visual abnormalities.

When Tom was interviewed by the psychiatrist, he was not very responsive. He appeared to be a child who accepted unpleasant situations without making any effective defense of himself. He seemed reluctant to talk about his family relationships and difficulties. Only when asked if he had any particular worry did he respond slowly and very seriously, "Yes, about getting my school lessons." He finally mentioned his fear of being less bright than the other children in his room at school. He mentioned that his teachers and parents predicted his younger brother would catch up with him in school.

When the mother was talking with the psychiatrist, she said, "Yes, I call him dumb. I tell him he gets dumber every day." She added, "We feel that he doesn't understand as much as the other children and so we aren't careful of our remarks about him when he is present." She was surprised when she was told that Tom was not defective but a boy of normal ability, who because of a marked reading handicap had not been able to function normally in school. The psychiatrist was uncertain whether or not she received the information with pleasure. She was told of the importance and urgency of a remedial reading treatment program for her son. She was advised to give him more attention, so that he would feel accepted by the family, to use appropriate encouragement and praise, and to give him responsibilities around the home which would help him feel more secure and confident.

While she accepted the comments and recommendations

intellectually, it was thought that she would be emotionally incapable of changing her attitude toward Tom in any important respect until she could see further evidence in his behavior that he was capable and worthy of more consideration.

The father, when interviewed, seemed to recognize that perhaps his handling of Tom was partly the basis for the boy's difficulties, but he was by no means ready to assume any large degree of responsibility for attempting to alter his attitude or behavior toward him.

Apparently even before Tom started to school he was a discouraged and unloved boy. Probably as a result of his family situation he lacked initiative, confidence, curiosity, and ability to pay close attention, all of which are extremely necessary for a child who is trying to learn to read. In school the vicious circle completed itself. Tom's trouble with his lessons increased the parents' anxieties about him, intensified their rejection of him, and furthered his own awareness of his inferiority.

In addition, Tom's difficulty was probably caused, to some extent, by constitutional and methodological factors. His school teachers had tried to teach him to read by the "look-and-say" or sight method, although he had difficulty in discriminating complex visual patterns and in sensing the direction of letters and words and was handicapped by a limited vocabulary. If his emotional problems had been less severe, he might have been able to succeed in reading even though the methods used in teaching him were not particularly appropriate for him.

Despite the fact that Tom's difficulty in reading was so closely related to his other fundamental problems, the staff believed that he might respond to reading therapy rather quickly. Because Tom's difficulty in reading offered a tangible remedial factor, it seemed to provide an excellent thera-

peutic approach to his problems. If the right reading tutor could be found she could probably assist him with his emotional difficulties by helping him to gain confidence in himself. This tutor should be a person who would feel that there is nothing uncommon or baffling about a child's failure to learn to read. Any progress he made in reading would itself contribute to the improvement of the total situation by giving him self-respect and demonstrating to his parents that he was an acceptable and worthy son.

The parents were unable to pay for private tutoring. Attempts were made to find a teacher at his school who would be willing to help Tom and who would have the desirable manner and attitude. The first teacher interviewed refused on the ground that Tom's difficulty resulted from his "don't care" attitude. She said he was lazy and added, "Why should I try to help him; he wouldn't appreciate it." Another teacher replied that she could not stand tutoring him because "he smells so bad." She believed "There must be something physically wrong, or he wouldn't wet his pants at his age. Maybe it's his tonsils." Several teachers dismissed the invitation with the explanation that they "didn't have time," or "What would the other children think, if this boy, who never tried anyway, were to be singled out for special attention?" Others assumed that Tom's situation was hopeless, remarking that "He must be subnormal or he would have learned to read in our school; all of our teachers have been well trained." Although all the teachers to whom the request was made were thoroughly trained in methods of teaching school subjects to groups of children, they had had little preparation for understanding and treating the special disability of this discouraged and sensitive boy. Furthermore, there was scarcely time in their full schedules to permit them to give individual attention to a single child.

Arrangements were made for Tom to come to the clinic

three times a week for remedial reading treatment. He was allowed to come alone since, in the mother's words, "It would satisfy his ego and increase his sense of responsibility."

In planning the remedial treatment program, the tutor first surveyed those factors which were impeding Tom's reading progress. The most important of these seemed to be the following: Tom lacked courage and confidence in himself. He had little awareness of the sounds of letters and was unable to blend sounds in word building. He was prone to make the following types of errors: confusion of consonants, reversals, and addition of sounds. He had difficulty in discriminating and remembering complex visual patterns and was frequently unable to react to even simple words as whole units.

Before much actual reading tutoring was done, the tutor became acquainted with Tom. She realized that comfortable and desirable emotional relationships are not as a rule developed quickly or automatically but are the gradual outcome of a leisurely process. The type of remedial training which was planned would take a long time, but it was the only kind which offered promise of being successful.

She played with Tom, went with him to places where he wanted to go. She neither pampered him nor dominated him, but was a genial companion who liked him and was always interested in his ideas and wishes. She was careful never to discourage him.

As a result of her friendliness Tom began to feel more comfortable with her than he had felt with any one for a long time. Here was a likable person for whom he felt respect and who was friendly toward him. Her esteem gave him increased confidence in himself. Soon his tenseness, his own anxieties about himself, and his feelings of inadequacy seemed to be gradually giving way to some degree of confidence. The third time he saw her he expressed the wish that



she help him with his reading, in which, he told her, he was "dumber" than in anything else. At this point remedial reading treatment was begun.

At the outset, it was assumed that the goal would be to have Tom reach the point where he could read large units quickly and easily. However, it was considered better for him to begin by reading sentences word by word or even words sound by sound than not to be able to read at all. Although it was desirable for him to learn to read many words "by sight," it would be more practical at the start for him to begin by learning how to "work them out" phonetically. Since the sight method, although profitable for the majority of children, had not been effective in his case, it was reserved for the later stages of training. There it would prove useful in presenting words which could not be correctly sounded out phonetically and in developing quick and rhythmic reading.

The tutor had conversations with him about sounds of letters and showed him the positions of the lips and tongue for articulating them. He practiced making the sounds before a mirror and soon enjoyed discriminating between them. He was then shown pictures of many different objects and was asked to select those beginning with the same sound and paste them on a page of a large scrap book. He correctly selected pictures of a peach, pumpkin, pup, and pie, all beginning with the "p" sound with which he had had considerable difficulty. "And what else begins with 'p'?" his tutor asked him. He quickly and correctly suggested several words. His attention was drawn to the letter "p" itself, and he spent some time writing and printing it on the same page with the pictures he had selected. Tom chose pictures of "toast," "train," "tomato," and "top" to illustrate the sound of the letter "t," and these, too, were pasted together on a single page of the scrap book. In similar fashion he se-



lected pictures for the letters "c," "m," and "n," all of which had given him difficulty. Considerable time was spent with the letter "b," since he frequently confused it with "p" and "d." By the time Tom had completed his illustrated sound dictionary, had sounded out the difficult consonants and watched in the mirror the way he made those sounds, he had developed considerable skill in discriminating letters and in associating the appropriate sounds with them.

After the study of consonants and a review of vowels, which gave Tom little difficulty, it was felt that he was ready to read many short words. The words were not presented in lists for fear they would not excite Tom's interest and curiosity. Instead they were introduced into games which it was known he liked.

For example, parchesi, which the tutor had taught Tom to play, had become his favorite game. This may have been due to the fact that, while his older brother owned a parchesi set, Tom had not been permitted to use it. Now it was easy to work words into the game as merely another aspect of it. A carefully selected word was printed in each of the spaces of the parchesi board. When Tom threw the dice and "got a six," for example, he was entitled to advance six spaces provided he could read the word in each space. He was not permitted to advance beyond the space where he made an error. He was told that he could have as much time as he desired and he was very careful to make the most of each throw. As the tutor took her turn, she pronounced the words on her spaces in unison with Tom.

A target game was also used to help Tom with his reading. A large target was drawn and colored, and a list of small words shown him. When he read a word correctly and fairly quickly, a mark was placed in the center of the target to indicate that he had "hit the bull's eye." When he required more time or made errors, the marks were placed propor-

tionately nearer the margin of the target. After he had pronounced all the words in the list, his score was computed. "Bull's eye shots" were given a score of 100, the next area out a score of fifty, the next ten. The maximum score possible was about 2,000, the minimum about 200. Each target was dated, so that it could be compared with previous day's records and subsequent ones.

Games were used primarily to stimulate Tom's interests and to help him feel that he was not doing "baby work." Although he had long been anxious to succeed in school, his experiences of failure had made it impossible for him to find pleasure in reading. The games substituted pleasant associations for former unpleasant reading association. A new attitude toward reading was gradually built up.

Through the use of special devices, graphs, and tables of scores, Tom was enabled to see for himself that he was making progress. Although the tutor frequently commented casually that he was doing well, praise was never very overt, because it was felt that Tom would put more stock in his success if he discovered it for himself.

At first it was not possible to find books which were within Tom's reading capacity and at the same time interesting to him. The usual first-grade books could not be used because they were written for children learning to read by the sight method and contained many words which phonetically were very difficult. Since Tom had failed to learn to read by the sight method, material was limited to what could be read phonetically by him. Because of the dearth of any appropriate books, the tutor wrote stories which would fit Tom's needs. Since she had grown to know him fairly well during the first weeks of tutoring, it was possible for her to write stories she knew would interest him. Words in these stories were carefully chosen so that he could read them instantly or work them out phonetically. The stories were put into

homemade books which were illustrated and made as attractive as possible.

Tom became very much interested in reading these books and frequently made remarks such as "Did you write this story all for me?" The fact that the books were specially prepared for him gave him additional evidence of the tutor's interest. Both the personal satisfaction and the reading practice itself benefited him. Finally the tutor suggested that Tom himself write the stories. "Why don't you think up an interesting story and tell it to me next time you come in?" he was asked. He came prepared. He told an interesting story, and the tutor wrote it down, simplified it somewhat, punctuated it, and typed it in an attractive booklet. Tom selected and pasted in the appropriate illustrations. The books were bound and each front cover proudly bore the title and the author's name. Of course, Tom read these books—his own!—with great interest, and the fact that he was writing books gave him a tremendous feeling of importance. Books, heretofore symbols of failure and discouragement, and now finally become representations of achievement.

In addition to helping Tom in these ways, the books gave the tutor further clues to Tom's interests and problems. It was significant that one of his favorites among the books he wrote was about the daily life at a Boy Scout Camp. From reading this book, any one would gain the impression that he was an active and capable Scout. The older brother had been active in the Scouts for some time, but Tom had repeatedly been told by his father that he would never be smart enough to be a Boy Scout.

As Tom continued with his reading, the tutor noted the particular words which caused his difficulty and used them as a basis for phonetic and kinaesthetic drill. Since Tom's reading showed an excessive error score in reversals, the sounding-tracing method was frequently used. The reversi-

ble letters, "b," "d," "p," "q," "u," and "n" were identified through movements in tracing them. Tom was taught how to sound out words as he wrote over the printed words. Superimposing the script movements over the printed letters helped him to develop the feeling of the direction of the letters and the words. By sliding his finger or a pencil along the text and thus gaining a kinaesthetic cue to direction, he gradually decreased his reversal errors. Although the phonetic-kinaesthetic method is slow and unnecessary in teaching the majority of children, it is effective for many children with whom the usual methods have proved unsatisfactory.

Tom's tendency to add sounds gradually decreased as he became more able to recognize words. Besides, he was given drill specifically intended to eliminate that tendency. Since he was inclined to add the "r" sound, word pairs such as "tap" and "trap," "dip" and "drip," "fame" and "frame" were presented to him. He was drilled also on such words as "round" and "around," "long" and "along," "sore" and "store." As he became more familiar with the sounds of letters and more aware of the errors he had been making, he less frequently added sounds to words.

In four weeks Tom had improved so much that it was thought he could attempt to read some published books. The books were carefully selected, however, so that he could read them without making too many errors. Books labeled "first grade" were avoided. The tutor knew that frequent errors would discourage him and cause faulty associations to be built up. In addition to selecting easy books, she anticipated as many of his errors as possible, so as to aid him before he made mistakes. Short goals were established in the realization that each one achieved would give Tom added confidence. So far as possible, great variety was introduced

into the lessons, and there were frequent reviews and special drills.

After Tom had been tutored for three months, he was reëxamined by the Monroe Diagnostic Reading Test. It revealed that he had made one year's progress. The examination also showed where he was continuing to have difficulty, and thus provided a basis for additional remedial reading work.

It had not been expected that Tom's reading treatment would immediately overcome his nail biting, his enuresis, his nose picking, and his other problems. In line with hopes, however, the treatment did lead to considerable improvement. Tom's diurnal enuresis decreased considerably, and he rarely wet his clothing during his reading lesson. In general he seemed brighter and more comfortable. It was apparent that his progress in reading had helped to relieve his tensions and feeling of inferiority to a great extent.

Tom will continue to be tutored in reading until his reading achievement is comparable to his mental ability. This goal cannot be quickly attained, but it is expected that eventually Tom will at least approximately reach it and thereafter make a satisfactory school adjustment. This in itself will be helpful in changing the parents' attitude toward him. It is evident that any improvement effected in their attitude and in the general home situation will in turn further facilitate Tom's reading progress and school adjustment.

**Discussion.** There are, of course, many ways in which Tom's problems and symptoms differ from those of other children who have difficulty in learning to read, and the methods used in treating him would not necessarily be appropriate for all children. In many important respects, however, his case is typical. First of all, it frequently becomes apparent that a child is retarded through no fundamental fault of his own; he has simply been mistaught. Tom, for exam-



ple, should not have been taught reading by the sight method exclusively. There are many children like him who may be spared unfortunate reading experiences where the reading methods employed are adapted to their individual needs and disabilities.

It is common for parents to believe, mistakenly, that all children who have reading difficulties are retarded mentally. In the case of Charlotte, discussed in Chapter VII, the discrepancy between the parent's opinion and the real facts was even more pronounced than in Tom's case. Charlotte had been sent to a school for defective children because she could not learn to read. Later, when she was examined at the clinic, she was found to have superior intelligence.

It is common, too, for children with reading difficulties to be very unhappy in school. The reason is evident. They realize that they are older than their classmates and often they feel that they are "dumber" as well. They are constantly confronted with their inability to keep pace in the work. It is not to be wondered at that they feel themselves misfits. As would be expected, they react violently to their uncomfortable situation, a situation in which at first they differ only in the way they read. Some children give up and assume an "I don't care" attitude. Usually the result is that children are considered lazy by their teachers, but they find it easier to accept the rôle of being lazy and unambitious than the rôle of being stupid.

Other children compensate for their inability to excel in school studies by becoming the school's "bad boys," teasing and bullying other children on the playgrounds and defying teachers and school regulations. These children are frequently given regular promotions despite their behavior, because one year with them is as much as many a teacher feels that she can stand.

Still other children face the problem and try desperately

to learn to read. They may be oppressed by the feeling that there is something seriously wrong with themselves; but they believe that by extreme effort they can learn what seems so easy for their younger classmates. However, unless they are given competent help their efforts are likely to be futile. Too frequently teachers simply dismiss this type of child with a glib: "What a pity. He tries so hard, but he just can't learn."

It is typical, too, for children with reading difficulties to have their problems made worse at home. In addition to experiencing discouragement and anxiety in the schoolroom and among their classmates, they are reminded of their inferiority in and by the family group. It is not necessary to discuss here the many reasons for a parent's anxieties following the realization that his child cannot get along in school. What we emphasize here is the effect of their anxieties. Parents may express their concern by nagging the child to work harder, by reminding him of his deficiencies, by contrasting him with other siblings, by threatening or punishing him severely, by offering rewards which generally cannot be won, or by spending hours trying desperately to teach the child to read. After a trained teacher has failed to help a child to make progress in reading, it is improbable that a disappointed and anxious mother will be successful. She may, instead, deepen the child's feeling of failure and inferiority.

It is not uncommon for the problems resulting from reading difficulty to assume greater significance than the reading difficulty itself. The children's maladjustment in the classroom in which they must live for the greater part of the day often initiates the development of many serious personality and behavior problems. These frequently result in a trip to a child guidance clinic, and it is not until after the various psychological examinations have been made at the

clinic that the trouble-making, specific reading difficulty is diagnosed.

Of all the school subjects reading stands out as the most fundamental. Consequently a great deal of interest has been shown in the study of children who are retarded in this subject. However, there are a smaller, but important, number of children who are brought to the clinic because of slowness or failure in other subjects such as arithmetic and spelling. Programs of treatment, similar in general outline to the one which has been described for reading difficulties, can readily be worked out for them.

On the other hand, such an approach, profitable as it is in the treatment of those school problems known as special disabilities, is not applicable in certain other types of school difficulties. For example, there are the children who, because they are doing work which is too easy and insufficiently interesting and challenging, need to have their environment adjusted to their capacities. They should be advanced and given work commensurate with their ability. Similarly, children who are trying to do work beyond their capacity should be placed in an easier situation with which they can cope successfully. For some of them placement in a prevocational school is desirable. This gives them the opportunity to develop the abilities which they have and which they will need to rely upon in later life and at the same time it frees them from the attempt to continue academic work for which they are ill equipped.

Whenever a child is having difficulty in school work careful study is necessary before there can be an understanding of his capacities, achievements, habits, and special weaknesses. No one method of treatment may be followed in every case. When the relationship between the child's abilities and the requirements of the tasks before him is understood, a constructive treatment program can be organized.

If the problem is simply one of a special disability for which there are remedies, a program similar to the one herein outlined may prove successful.

In the foregoing case studies the failure of proper direction, training, or control has centered in the home or in the school. By these illustrations we have made it clear that broken homes, unstable, misguided, or otherwise inadequate parents, and the inability of teachers to cope with the special disabilities of their pupils occasion many of the more serious problems brought to the child guidance clinic. Treatment for these problems usually requires modification of whatever underlying situations are unfavorable to the child's development. To the clinic, also, come children who have become delinquent. Very often study of these children points to a failure, not so much of the home or the school, as of the neighborhood or the community as a whole. This raises the problem of altering these wider environmental influences which so seriously interfere with the development of personality in the children affected.

Many decades ago it was recognized by students of delinquency and crime that the amount of delinquency in certain community situations is much greater than it is in others. In the earliest ecological studies of delinquencies comparisons were made chiefly between different cities or large districts within a given country. During the early part of the last century numerous statistical studies and government reports were published to show that the number of known criminals in relation to the population varied widely among the counties of England and Wales.

As early as 1839 Rawson reported that the relative number of criminals was five times greater in certain counties of England than in others. Twenty-three years later Henry Mayhew concluded what seemed to be then a rather exhaustive study of delinquency and crime in the various



counties of England. Among other things, he published a series of maps showing the incidence of criminality and various types of crime by counties. He reported that the incidence of criminality in certain counties was almost four times greater than in other counties. The number of crimes per 10,000 inhabitants in the total population ranged from 26.1 to 7.1 in the forty-one counties of England and Wales.

In 1856, John Glyde published a study showing the relative number of criminals in the seventeen poor law unions in Suffolk County, England. The ratio between the number of criminals and the population ranged from one in 1,344, to one in 464 inhabitants in the seventeen subdivisions of the county. Wide variations in the incidence of delinquency were also noted as between the urban and rural districts and as between different cities in the county. Glyde concluded his report by stating that: "as tables of crime for all England include counties of various degrees of criminality, so does the average for the county of Suffolk include districts, towns, and villages of opposite moral tendencies as developed by their criminal aspects." \*

Similar findings have been reported by Lombroso, Ferri, and Niceforo, in Italy, Tarde and Joly in France, Aschaffenburg in Germany, and Beurle in Austria. All of these students reported wide variations in the incidence of criminality in different districts in various European countries. As might be expected their interpretations of these differences are widely divergent.

Systematic studies of the relative incidence of delinquents in local districts within cities was of more recent development than the more general studies just mentioned, although the close association between conditions prevailing in particular districts within the city and the incidence of delinquency was

\* John Glyde, "Locality of Crime in Suffolk," *Journal of the Statistical Society of London*, Volume 19, 1856, pp. 102-106.



emphasized throughout the early official reports and investigations of crime in London. In these reports frequent reference is made to the so-called "low neighborhoods" in which delinquents, criminals, prostitutes and other groups associated with delinquency were especially prevalent.

These early observations received statistical confirmation in such an investigation as Burt's study of juvenile delinquency in London.\* In this study, Burt secured the home address of each boy and girl reported as an industrial school case during the years 1922 and 1923 and calculated the ratio between the number of cases in each electoral area in London and the total number of children on the rolls of the council's schools. This ratio for the several areas ranged from 0.42 to 0.0, while the average for the city as a whole was 0.14. The map for the entire city indicates that the areas having the highest rates (0.25 and upwards) are located adjacent to the central district of London, while those having the lowest rates (0.05 and less) are located in the outlying sections near the periphery of the city. It is interesting to observe, also, that "the low neighborhoods," which were regarded by the early students as the chief source of delinquency, fall within the areas having the highest rates of delinquency. Furthermore, these areas of delinquency correspond rather closely with the poverty areas revealed in the early study which was made by Charles Booth.†

During the last two decades various studies of the distribution of juvenile delinquency in American cities have been published. In 1912, Breckenridge and Abbott published a study showing the geographic distribution of cases of juvenile

\* Cyril Burt, *The Young Delinquent* (D. Appleton and Company, London, 1925), pp. 67-90.

† Charles Booth, *Life and Labor in London*, Appendix to Volume II (Williams and Norgate, London, 1889, Map of London Poverty by Districts).

delinquency in the city of Chicago. They utilized for this purpose the cases of boys and girls brought before the Cook County Juvenile Court on petitions alleging delinquency during the years 1899-1909. Among other things they prepared a map showing the location of the homes of these children. This map indicated that a disproportionately large number of the cases were concentrated in certain districts of the city. In this connection they state:

A study of this map makes possible several conclusions with regard to "delinquent neighborhoods." It becomes clear, in the first place, that the region from which the children of the court chiefly come is the densely populated West Side, and that the most conspicuous centers of delinquency in this section have been congested yards which lie along the river and the canals. . . .

While the West Side furnished the largest quota of delinquents, there are, of course, other centers of delinquency across the river. These are chiefly the Italian quarter of the Twenty-second Ward on the North Side; the First and Second Wards which together include the district of segregated vice and a portion of the so-called "black-belt" of the South Side; and such distinct industrial communities as the districts near the steel mills of South Chicago and near the stockyards.\*

In 1915, Professor E. W. Burgess, under the direction of Professor F. W. Blackmar, conducted a survey of social conditions in Lawrence, Kansas. This survey included a study of the geographic distribution of alleged delinquent children for the city as a whole, the absolute number of delinquents in various districts, and the rates of delinquency for the several areas. Both the number of cases and the rates of delinquency show wide variations among the several areas. The ratio between the number of alleged delinquent children

\* Sophonisba P. Breckenridge, and Edith Abbott, *The Delinquent Child and the Home* (The Russell Sage Foundation, New York, 1912), pp. 150-153.

and the total population aged five to sixteen years varied from 8.36 to 0.82 for the six wards of the city. In this connection Professor Burgess states:

The significant fact to be gathered from the records of the children of Lawrence is the large proportion of juvenile delinquents in the entire child population in the fourth ward. One child out of every twelve children more than five years old but under seventeen years appeared in the juvenile court in the two-year period studied. If this proportion were maintained for a twelve-year period comprising the age groups between five and seventeen, the presumption is that at least one-half of the children in the fourth ward would have appeared before the juvenile judge before reaching seventeen years. Since the proportion of juvenile delinquency in the fourth ward is three times as large as that in any other ward, the conclusion naturally follows that certain factors are at work here which are absent elsewhere in Lawrence. . . .

The low percentage of delinquency in wards 5 and 6, in North Lawrence, is to be accounted for by the semi-rural character of the community, with its opportunities for play, and by the distance from the industrial and business part of the community. . . .\*

Two years after the publication of the Lawrence Survey, Professor R. D. McKenzie conducted a general study of Columbus, Ohio. In addition to showing the actual geographic distribution of the homes of delinquent children, this study also included rates of delinquents by wards, along with certain indices of neighborhood situations, and an intensive study of a local community. The rate of delinquency, which in this study represented the ratio between the number of delinquents and the number of registered voters, ranged from 1.66 to .35 for the sixteen wards of the city.†

\* F. W. Blackmar, and E. W. Burgess, *Lawrence Social Survey*, Lawrence, Kansas, 1917, pp. 71-72.

† R. D. McKenzie, "The Neighborhood." *American Journal of Sociology*, 28:166 (1928).

It is important to note that a similar pattern of distribution of the home addresses of delinquents was revealed in sixteen American cities in which the Behavior Research Fund of Chicago and the Institute for Juvenile Research have made ecological studies. In all of these cities, as in Chicago, the greatest concentration of cases and the highest rates by unit areas occur in districts in or adjacent to the business center and the major industrial developments. In neighborhoods further removed from these business and industrial centers, the cases of delinquency and crime are fewer and more widely distributed. In all of these cities, also, there is a general tendency for the rates to vary inversely in proportion to distance from the commercial and industrial centers.

The marked uniformity in the pattern of distribution of the home addresses of delinquents in various American cities and the constancy of the pattern over a long period of years suggest a close relationship between the incidence of delinquency in local areas and the varied community situations differentiated in the natural process of city growth. The areas of high delinquency rates possess certain characteristics which differentiate them from the outlying residential areas where the rates of delinquency are relatively low. Presumably the high rates in the areas adjacent to the commercial and industrial areas reflect the economic insecurity, political corruption, tradition of delinquency and crime, social disorganization, limited opportunity for constructive uses of leisure time which generally obtain in these sections of an American City. For the most part, the rates in these areas have been persistently high notwithstanding the successive changes that have taken place in respect to nationality among the inhabitants. The rates remain relatively constant, despite successive changes in the nationality of the population successively residing in them.

## John

The manner in which the various conditions in the "slum" districts of Chicago contribute to delinquency among children is concretely illustrated by the case of John. At the age of seventeen years, John was arrested on a charge of automobile theft and hold-up with a gun. He and his companions, when arrested, readily admitted stealing the car, which was in their possession when the arrest was made. Inasmuch as John was on parole from a correctional institution at the time, he was returned to the institution without the formality of a court hearing.

Even at this early age John was confirmed in habits of stealing and skilled in the use of the various techniques and artifices of the habitual youthful offender. His initial acts of delinquency had occurred when he was approximately seven years of age. These consisted chiefly in various forms of petty theft, which included stealing iron and lead pipes from old buildings, pennies from news stands, merchandise from trucks, and fruit from local neighborhood stores. He persisted in these practices and when nine years old was apprehended with his companions and brought before the Juvenile Court. In addition to his stealing, it was revealed that John persistently played truant from school and had on some occasions remained away from home all night. On these findings he was committed to a correctional institution.

After a period of confinement of three months in this institution, John was returned to his home on parole. He continued to play truant from school and to engage in his stealing activities, as before. Consequently at the age of twelve he was again brought to court. On this occasion he and three companions had forced entrance into a residence and stolen money and various articles of jewelry. He was again returned to his home and placed under the supervision



of a probation officer from the court. When he was returned to the court three months later, charged with complicity in the theft of an automobile, he was committed to another correctional institution. Three days later he escaped from the institution and returned to his home. His parents promptly took him back to the institution, but he escaped again.

After his second escape from this institution he became a member of a group of youthful burglars who lived in his neighborhood. With these companions, he was involved in a long series of burglaries for which he was finally apprehended at the age of fourteen and committed to a third correctional institution. After remaining in this institution for a period of two years he was returned to his home and placed under the supervision of a parole officer. Immediately thereafter he became involved with a neighborhood gang in burglary, jack-rolling, stealing automobiles, and stripping cars. After being on parole two months he was arrested for stealing automobiles, burglary of several drug stores, jewelry stores, and clothing stores, and was returned to the institution as a parole violator. Shortly after his final parole from this institution he was convicted for armed robbery and sentenced to a penal institution.

**Discussion.** The record of John's officially known offenses possesses certain features in common with many of the cases of habitual youthful offenders in the delinquency areas of the city. His initial acts of delinquency occurred at an early age; they consisted chiefly of truancy from school and various forms of petty stealing in the immediate vicinity of his home. The case illustrates, also, the usual progression from the simpler acts of delinquency in early childhood to the more serious forms of delinquent and criminal conduct in the later years of the period of adolescence. These later acts of crime, which required greater skill and more sophisticated techniques, reflect the result of a long sequence of

antisocial experiences extending over a period of ten years. It is only in relation to this background of experience in delinquency that John's crime of armed robbery at seventeen years becomes explicable.

Any analysis of the ætiology of John's delinquency necessarily must be tentative. The present state of knowledge of the nature of delinquent conduct is altogether too tenuous to warrant final conclusions in regard to the factors which contribute to delinquency in any individual case. Consequently, the following brief discussion is largely speculative in character.

Three times in the course of John's career in delinquency he was referred for clinical examinations. These examinations did not reveal any physical or mental conditions which would seem, to the writer at least, to be significantly related to his delinquency. His developmental history was reported to be essentially normal. Aside from carious teeth and a slightly enlarged thyroid gland his physical condition appeared to be normal. The results of mental tests revealed that he possessed average intelligence (I.Q. 97). The examination did not disclose any neurological pathology or peculiarities of personality. It was evident that John encountered no special difficulty in establishing and maintaining friendly and congenial relationships with other boys of his age.

The family in this case consisted of the father, mother, and John. The parents had immigrated to this country when they were about twenty years of age and lived on a farm until John was born. At that time they moved into the city and established a home in the area in which they lived at the time of John's first arrest. As might be expected, the parents were quite unsophisticated in regard to the conditions of life in the slum districts of Chicago. While they were industrious, moral, and greatly interested in John's welfare, it was equally apparent that they were bewildered, perplexed,

and confused by the truancy, delinquency, and crime in which he became involved at an early age.

Investigation of the family indicated that John and his parents had very few interests and values in common. His attitudes, interests, and ideational life were defined in terms of the activities in which he engaged in the community, while the attitudes of the parents reflected their old world rural background. In this connection, John states: "I always felt that I never understood my father and mother and that they never understood me. We never used the same language or had the same ideas about things."

The wide disparity between the cultural background of the parents and the local social world in which John lived contributed in part at least to the ineffectiveness of the family as an agent of control and as a medium for the transmission of cultural heritage. In this situation the parents resorted to severe forms of corporal punishment to enforce and to correct John's conduct. This severe discipline tended further to enlarge the gulf between them.

It is of primary importance to observe that John was relatively isolated from the cultural traditions and moral standards of our conventional society. So far as could be ascertained he never participated in the activities of any group or institution whose standards and traditions were consistent with our larger conventional society. He lived in one of the most deteriorated and disorganized areas in the city of Chicago. This community lacks the homogeneity and continuity of cultural traditions and institutions which are essential to neighborhood organization, and the formation of effective public opinion. Throughout the entire period of John's childhood and adolescence this area has been notorious for its organized crime, gang wars, political corruption, protected vice, and delinquency. The rates of criminality among the young men aged seventeen to twenty-one have been ex-

tremely high in this area for many years. "Jack-rolling," shop-lifting, junking, burglary, and other forms of stealing have been common activities among many of the boys of the area during the last two decades. Each year as many as 15 to 25 per cent of the boys aged nine to seventeen years come to the attention of the police officers because of delinquency. This rate, however, is an inadequate measure of the extent of delinquency in which the children of the area engage, since many of those involved in delinquent practices are never apprehended by the police. Delinquent techniques and practices constitute a part of the common social heritage and traditions which are transmitted through the spontaneous play-group and gangs in which the neighborhood participates.

Children who grow up in this deteriorated and disorganized neighborhood of the city are not subject to the same constructive and restraining influences that surround the child in the more homogeneous residential communities farther removed from the industrial and commercial areas near the center of the city. The neighborhood fails to provide a consistent set of cultural standards and a wholesome social life for the development of a stable and socially acceptable form of behavior in the child.

Very often the child's access to the traditions and standards of our conventional culture are restricted to his formal contacts with the school, the court, and the police. On the other hand, his most vital and intimate social contacts are often limited to the spontaneous and undirected neighborhood play groups and gangs whose activities and standards of conduct may vary widely from those of the larger social order. These intimate and personal relationships rather than the more formal and external contacts with the school, the police and probation officers, and neighborhood institutions, become the chief sources from which he acquires his social values and conceptions of right and wrong.



As might be expected, the facilities for constructive supervised activity for the children in this neighborhood during their leisure time are extremely meager. The two local agencies which offer such programs, when functioning to the extent of their maximum capacity, could not provide adequately for more than approximately 40 per cent of the juvenile population of the neighborhood. John was never enrolled in the membership of either of these agencies. In fact, he never participated in any supervised recreational program in the neighborhood. His leisure time activities were limited largely to the spontaneous, random play-life of the natural groups and gangs in the area.

In this area as in other delinquency areas of the city, these unsupervised groups serve as a medium through which the traditional delinquent practices of the neighborhood are transmitted from the older to the younger member of the local population. The ethical values, standards, interests, and ideals of these groups are often widely different from the standards of the play groups in the residential communities of higher economic status. In fact, the moral standards of these groups may represent a complete reversal of the standards and ethical norms of conventional society. Specific acts of conduct which result in personal degradation, loss of status, and dishonor in a conventional group may serve to enhance and elevate the prestige and status of the members of a delinquent group in this community. For example, an appearance in the Juvenile Court, a period of incarceration in a correctional institution, the manifestation of great courage and daring in combating the police, the display of unusual skill and finesse in the execution of acts of delinquency, the effective employment of artifice and trickery in misleading the probation officer and the court, the clever use of epithets in deriding and ridiculing the boy who does not engage in delinquency are forms of behavior which are



not only condoned in the delinquent groups but are employed to effect a closer identification of the individual with his group and to enhance his status and prestige in relation to his companions.

John's earliest delinquencies were in strict conformity with the forms of delinquent activity which had prevailed in the neighborhood for many years. Obviously the techniques which he employed in his delinquencies were assimilated from the groups and delinquents with which he had intimate daily contact. His interests in delinquent activity were developed and confirmed in the course of his participation in the spontaneous social life of his play group and neighborhood.

It is important to note that the various methods of treatment employed in this case were not effective in checking the delinquency. John continued to engage in delinquency year after year despite the fact that he was repeatedly brought to court, placed on probation several times, confined in three different correctional institutions, and placed under parole supervision four times. In each instance of probation or parole he was returned to the same situation in which his delinquencies had occurred. The probation and parole supervision consisted chiefly of monthly visits to the home on the part of the officers from the court and the correctional institutions. His contacts with the officers were not only infrequent but were largely formal in character. It is probable that the three periods of confinement in institutions tended only to confirm his delinquent tendencies. In any event, after his return to his home from each institution he promptly renewed contacts with delinquents and engaged with them in further delinquent and criminal practices.

The boy whose case is presented in the preceding pages in many respects resembles a large percentage of juvenile delinquents and youthful criminals living in the deteriorated

areas of American cities. For the most part the delinquent activities in these cases are presumably a function of the social and cultural traditions of the local community. If this assumption be valid it follows that any program for the treatment of individual delinquents and the prevention of delinquency in such areas should approach the problem from the standpoint of the neighborhood as a whole. In addition to utilizing various techniques for the treatment of the individual and the family, emphasis should be placed upon the development of community organization. Whether or not this end can be achieved is open to very serious question. Until such general changes are effected, however, it is altogether probable that any attempt to rehabilitate the young delinquent under such conditions will be relatively ineffectual.

It must be recognized, also, that the demoralizing conditions that obtain in the "slum" districts are an integral part of the life and structure of the city and of the larger social order and that any substantial reduction in the incidence of delinquency in such areas is perhaps impossible except where changes in the economic, political, and social system of which the local community is an organic part can be brought about. In view of these considerations it is obvious that any approach to the treatment of delinquents and the prevention of delinquency in the large proportion of cases must be both comprehensive in scope and experimental in character.

## Chapter XIV

### PROBLEMS ARISING FROM THE CONSTITUTIONAL INADEQUACY OF THE CHILD

#### Melvin

SIX-YEAR-OLD Melvin, an only child, was brought to the child guidance clinic by his worried parents, after they had been told by the school principal that the boy was not yet ready for the first grade. The year before, when Melvin was five years old, he entered kindergarten. There he wandered about aimlessly, slapped at the children, and wet his clothes. After a week the school asked that he be removed. Determined to "bring him up to par" after this failure of adjustment, Melvin's parents arranged for a college student to live in the home and to give the boy lessons for two hours each day. During this year Melvin acquired good toilet habits, and the parents insisted that now he was ready for school.

The parents, high school graduates, comfortably situated financially, had been eager for a child. However, shortly after the mother became pregnant, the father's parents fell ill and were in the home until their deaths several months later. The mother, exhausted by the strain and worry of nursing the old couple, became ill and depressed. This condition continued until Melvin was born. The birth was difficult and prolonged, although no instruments were used. The parents were delighted with their boy and lavished affection on him. He was not a sickly baby, and it was not until he was three that they began to realize that he was developing

slowly. At that time a visit from a child the same age, who could talk in sentences, brought home to the parents the fact that Melvin, who could speak only a few isolated words, and who had been walking only a few months, was far behind the other three-year-old in development. The father searched the department stores for elaborate "educational" play equipment, but Melvin showed little interest, preferring to bang with a spoon or a tin pan to playing with the equipment which his father had purchased.

When Melvin was four years old, an attempt to enter him in the pre-kindergarten groups at his Sunday School was unsuccessful, as he stubbornly refused to leave his mother.

After the week at kindergarten when Melvin was five, the father decided that stern measures were needed. When Melvin disregarded orders he was spanked. When he failed to remember the alphabet and nursery rhymes on which he was drilled daily by the tutor, his father was angry and called him a stubborn little boy. Melvin was restless and irritable after each lesson. His parents believed that he needed the companionship of other children and bribed an eight-year-old boy to play with him. For a time Melvin looked on while his guest played with his toys, then he began throwing blocks, and the older boy went home disgusted.

At six years of age, Melvin could speak in simple sentences. He could feed himself and attend to his toilet needs, but could not dress himself. He refused to stay in a room by himself and followed his mother about constantly until, in her words, "He nearly drove me crazy."

At the clinic it was found that although rather small for his age and immature in appearance, Melvin was in good health. The psychological examination indicated that he was extremely dependent and responded to questions only after a great deal of encouragement. His mental development

## Constitutional Inadequacy of the Child 293

was found to be slightly less than that of the average four-year-old child.\* Melvin was obviously not ready to enter first grade.

When the psychiatrist talked with the mother she broke down completely and sobbed out her confession that she had realized that Melvin was not ready for school, but that the father, several years her senior, made her feel that if the boy was unable to learn it was because her training was at fault. Perhaps, she added, it was all her fault. She had hated having to care for two helpless old people at the time she was pregnant and had felt resentful toward the father for being indirectly responsible for the burdens put on her. Later, she had forced herself to devote herself to Melvin to the exclusion of all outside activities. As a result she was "nearly distracted" and had welcomed school placement as a solution of her own problem, as well as a means of proving to herself that Melvin was really all right.

In talking with the psychiatrist the father took the attitude that Melvin really was bright, but just couldn't express himself. He spoke of his educational plans for the boy—high school and then university.

Both parents were anxious to know at once the result of the clinic study. It was necessary to explain to them the fact that Melvin was at least two years retarded, mentally, and that his failure to respond to tutoring was due to inability rather than to stubbornness. Because of the tension at home and because public school placement was out of the question, placement of Melvin in a boarding school for retarded children was suggested as a possible means of relieving the immediate situation. Financially, the parents could have afforded such a plan. They asked for a little time to think over the matter. A week later they reappeared at the clinic and announced that, while for the time being

\*This would classify him as a high-grade mental defective.



they wished to keep the boy at home, they would welcome help in facing their problems.

In further treatment of the case, the psychiatrist reassured the mother in an effort to remove her vague worry that the boy had been "prenatally marked" by her resentment of the bedridden grandmother. The parents were told that if they were to have another child the probability was that it would have normal intelligence. The mother was commended for her success in teaching the boy good toilet habits, and it was suggested that during the next two years she emphasize training in dressing himself and in the care of his person and his belongings. A social worker from the clinic visited the home and worked out with the mother a simple routine for the boy. His elaborate play equipment, suited to a boy much older mentally, was put aside and simple toys substituted. The mother was advised to make opportunities for Melvin to play with children two or three years younger than himself, rather than with boys eight years old. The mother was also encouraged to arrange to leave him in the care of the maid, a competent person, for a stated time each day so that she might re-interest herself in some of the outside activities which she had long neglected.

A month later the parents again came to the clinic to report that things were going more smoothly at home. They had discontinued the tutoring and had found that as a result Melvin seemed happier and less stubborn. They were pleased with the change in the boy and planned to continue the program suggested by the Institute. The parents were advised to bring Melvin into the clinic in two years' time, to check on his progress and to plan for his future training. In the meantime they were invited to feel free to confer with the clinic staff should they wish to discuss their problem further or should new difficulties arise.

In this case treatment was directed first toward helping

the parents to accept the fact that their child was retarded; second, toward relieving the mother's guilty feeling based on a superstitious belief that she was in some way responsible for the retardation; and third, toward helping them to plan for the boy's training and education.

**Discussion.** Many children referred to the Institute present some degree of mental retardation,\* and it is the function of the clinic, as in the case just cited, to aid in formulating for each child plans which take into consideration the interest of the child, his family, and the community. It is also the function of the clinic to be familiar with and make available for each child, all the existing community resources which can contribute toward the working out of these plans.

It is a common observation that children and adults vary in their intellectual endowment. Some children are advanced for their age, and some fewer are even precocious. Others are slow to develop and are either retarded or arrested. It is estimated that from 1 to 3 per cent are so retarded as to be classified as feeble-minded.† In from one sixth to one fourth of the institutionalized cases the retardation is occasioned by disease or injury involving the brain.§ In the remainder of the cases the defect appears to be innate, for no pathological explanation can be found.

The degree of mental deficiency is, of course, the prime factor to be taken into consideration in planning a program for a feeble-minded child. The personality of the child, his ability to adjust socially, the composition of his family, the quality of supervision offered by the home and community, the possibilities he presents for becoming at least

\* See Chapter VII.

† Rudolph Pintner, *Intelligence Testing, Methods, and Results*, second edition (Henry Holt and Company, New York, 1931), pp. 336-339.

§ A. T. Tredgold, *Mental Deficiency*, fifth edition (William Wood and Company, New York, 1928), p. 244.

partially self-supporting, are additional factors which must be considered.

Perhaps the most important thing that the clinic may give to the parents of the feeble-minded child is an understanding and, so far as is possible, an acceptance of the child's limitations. The constant prodding which parents are apt to use in their efforts to make the child keep up with others who are brighter than himself is only too frequently merely destructive of the child's adjustment.

The retarded child should be taught without undue pressure what he is capable of learning, and he should be encouraged to do things for himself. Through patient encouragement he should learn to attend to his toilet needs, to wash and dress himself, and to brush his teeth. As he develops mentally he should be taught simple manual tasks such as dusting, sweeping, or digging in the garden.

Care should be taken to cultivate in the child the best possible social adjustment and, so far as is possible, a tractable, good-natured disposition. The cultivation of the habit of obedience should be stressed. Obedience is a pattern which is usually of only temporary value to a child, serving to tide him over until such a time as his own judgment is developed. The retarded child may never reach the point of being able to maintain himself without supervision and direction, and if he does reach this state he will achieve it more slowly and less completely than does the child of average intelligence.

In neighborhoods where delinquency is common, retarded boys and girls are particularly prone to adopt the behavior patterns of delinquency. Being suggestible and easily influenced, they are quick to accept any means offered them for gaining recognition and may become the tools of delinquents older or brighter than themselves. Thus a dull boy may learn to steal and a defective girl may readily become

a sex offender. Once these patterns are established they are difficult to alter. Often it is impossible for the home or the community to offer adequate supervision of such boys and girls, and commitment to an institution for the feeble-minded becomes the only alternative to a delinquent career.

However, here again we find wide variations in the behavior of children of the same age and mental level when personal and social factors are taken into consideration. Take the cases of Jack and Tony, who happened to come to the clinic the same day. Both were fourteen years of age, both were failing in their school work, and both were classified by the psychological tests as high-grade mental defectives.

Jack came from a comfortable middle-class home. He was a husky boy, and according to his mother was accepted as a member of the neighborhood ball teams, although such adjustment in complicated team play is exceptional in our experience. He was far behind his friends in school and was ashamed of it, but he managed to conceal this fact from the boys in the neighborhood by carrying some of his brother's high school books with him when he went to and from his school, a school at some distance from the one attended by his friends. Although poor at academic work he was industrious and the previous summer he had worked as a helper for a local contractor. He could load bricks and cement "with the best of them." He was good natured, amiable, and no problem at all to his parents aside from the fact that they were disappointed by his inability to finish eighth grade and to go on to high school. The recommendations of the Institute were that Jack be transferred to a prevocational school where he would receive a minimum of academic work and a maximum of manual training, and that as soon as possible he be placed in a full-time job.

Tony came from a home in a poor neighborhood where



the delinquency rate was high. His father had deserted his mother, a dull, ineffectual woman, and had left her with three children. Tony frequently played truant from school. One day at school he set fire to a little girl's book. Often he stole money from the neighbors and from his mother. He was undersized and unattractive and evidently felt flattered when older boys in the neighborhood chose him as their friend, as they did prior to an occasion when they lowered him through a transom in a house so he could unlock the door, after which they proceeded to burglarize the house. Once he was found engaged with a little girl in sex play. Because an outbreak of serious delinquency seemed almost certain and because there were no resources available for the adequate supervision of this boy in the community, commitment to a school for the feeble-minded was recommended for Tony as the best step to take for the protection of the community, as well as for his own protection.

The mere fact of feeble-mindedness should never by itself alone be considered sufficient reason for commitment. This is true even where there is such gross retardation that the child is classifiable as an idiot or imbecile and it is evident that he will be dependent on others all his life. All the factors in each case must be weighed before a decision is reached as to whether or not he should be institutionalized. If the family is able and willing to keep the child at home, it may be best that he be allowed to remain there so long as he can be given adequate care. If, however, he is destructive or violent, if he exerts a detrimental influence on the development of other children, or if he requires so much attention that the parents are unable to give their other children adequate care, his placement in an institution for the feeble-minded should be recommended.

When plans for defective children are being made, parents are urged to take a long-time view of the matter. The parents



of one imbecile boy whose violent behavior made it impossible to consider caring for him at home were ready to mortgage their home and spend all their savings in order to place the boy for a year in a sanitarium in the hope that he might improve. It became the task of the clinic to try to help these parents understand and accept the fact that even this expensive treatment could effect no cure for feeble-mindedness. They were told that the boy could never become self-supporting even with the most favorable placement. It was urged upon them that it might be wiser to place the boy in the State institution where he would receive adequate custodial care and then use their limited funds for the education of their three other children, all of whom were of normal intelligence.

While less obvious than the problems presented by the grossly defective child, the problems of the dull child below the borderline of normal intelligence are equally serious. Often children who are somewhat retarded are not recognized as such by their parents and teachers. Their poor school work may be attributed to "laziness" and "orneriness" or to failure to concentrate. Frequently such children are placed in school rooms with other children of their own age and size, but of superior mentality, and are urged on to achievement quite beyond their abilities. At home, the parents may emphasize school achievement and compare the dull child unfavorably with other children in the family. In one case examined at the clinic the mother urged the younger brothers to "shame" the oldest boy, who was behind in school, hoping in that way to get him to study harder. Children thus treated often become discouraged, fail to utilize even the ability they do have, and take out their resentment and feeling of failure in ways which are socially unacceptable.

When such children are placed in special rooms in the school, given individual instruction, and allowed to progress

according to ability, they are relieved of some of the pressure of unequal competition and become able to enjoy the sense of achievement over each new accomplishment, no matter how small it may be.

Public school systems throughout the country are endeavoring to meet the needs of retarded children by setting aside special rooms and "opportunity schools" for those who are not able to profit by the usual academic curriculum and who need special training along manual lines. The Institute staff is familiar with the educational resources offered by the child's community and endeavors to interpret the child's needs to the school and the school's resources to the parents.

Many private boarding and day schools have been established to care for retarded children. When placement of a child in a private school is considered advisable, the clinic is prepared to act as consultant and to furnish the parents with information so they can find a school suited to the needs of the child and their financial resources.

In Illinois, providing institutional care for mental defectives who require it is a function of the State, and in order to obtain such care the patient must be declared feeble-minded and committed to the State institution by court order. It is the practice of the Institute not to advise placement of a retarded child in a State institution unless his presence in the community is likely to prove detrimental to himself, his home, or to the community in general. When this type of solution is recommended after study of a case, the clinic staff discusses the plan with the parents and explains the commitment procedure. Many parents look with horror at the idea of commitment to a State institution and believe that in such a place an individual will receive only custodial care. In many instances this has been and unfortunately still is true. The more progressive institutions have introduced a

training program consisting of only a limited amount of academic school work, related to the every day life of the child, along with a large amount of manual activity such as cooking, sewing, and care of children for the girls, and farm work, carpentry, and painting for the boys. Where recreational programs have been introduced the response of the children has been whole-hearted. Of course many children are so grossly defective as not to be capable of profiting by these provisions. On the other hand, there are in every State school for the feeble-minded many young people and adults who are able to function satisfactorily under close supervision, but who soon get into trouble when exposed to the confusion of the outside world. Institutions such as the Rome Colony in New York have met this problem by providing, as the name implies, a "colony" type of organization in which the individual can become partially self-maintaining and at the same time remain under supervision. Often after periods of training in such a school, either public or private, individuals are able to return to their communities and take up useful if inconspicuous places in society. Others, unable to become self-supporting and requiring constant care, remain in the institution for the duration of their lives.

All these possibilities are discussed with the parents in the light of the circumstances of each case. It is important for the staff to be familiar with all the State institutions and not to describe any one of them in terms more or less favorable than the facts justify. If this has ill-advisedly or inadvertently been done the parents may later feel resentful toward the clinic, with greater or less justification. Usually, if possible, it is best for the parents to visit the institution before placing the child in it.

While the staff, through the clinic study, may arrive at an estimate of the child's ability and aptitudes and be able to make suggestions how to utilize whatever resources the

child has, there can be no way of supplying the child with intelligence which he does not already possess. Contrary to the hope of some parents who cling to the idea that in some magical or miraculous way the clinic will make a dull child bright, no "cure" for feeble-mindedness has as yet been found. Tactful but firm insistence upon the necessity for recognizing this fact by all individuals concerned with the care of retarded children is a definite aspect of the clinic's service.

### Hilda

Hilda, an eight-year-old girl, was first referred to the Institute for Juvenile Research because she had recently been raped by a fourteen-year-old boy. The family were reticent about giving information concerning any difficulty they had had with her and objected to maintaining contacts with the clinic. Seven years passed. Then the family on their own initiative brought Hilda, now fifteen, to the Institute for study. At this time the family admitted that she had been a problem since infancy and that they were anxious for advice because all of their own methods of control had failed.

The history revealed that when only two years old Hilda ran away from home and offered resistance to any parental guidance. She frequently stole money from her parents and lied to them in the face of conclusive evidence against her story. In the later years when she ran away she always made the acquaintance of some man. Each of the men, so far as could be determined, befriended her but none of them ever made sexual advances to her. Her family placed her in a correctional institution for a time, but her behavior was unchanged after her release.

Hilda was an attractive girl with a refined manner and an almost "Madonna-like" appearance. She seemed quite mature. The psychological examination revealed that she had



superior intelligence. Her parents spoke disparagingly of her and contrasted her unfavorably with her sister seven years younger, who was reported to be without any of Hilda's faults and to surpass her in all her good points. The parents were born in Sweden and had retained many of the standards of their old-world culture. They stressed their desire to be respected by their children, suggesting in their manner and in their comments that Hilda had been quite deprived of their affection because of her behavior. They themselves had practically no social contacts in the neighborhood because the neighbors discussed Hilda's delinquencies, condemned her as a "bad girl," and implied that they were responsible through unwise handling of the situation. The impression concerning Hilda's case recorded at that time was that she was an adolescent girl who, because she was being curbed in an unwise manner, was making a clumsy and ill-planned attempt to find herself as an adult. Her normal growth to adulthood was threatened. Temporary removal of Hilda from her home was recommended as a way of providing a period in which Hilda's needs might be interpreted to the family, a more understanding attitude toward her worked out with them, and an opportunity given to study Hilda's behavior in a more suitable environment. She was sent to a camp where she would experience more normal, and less restricted, social contacts. She immediately adjusted to the camp, became a favorite with the girls, and was very acceptable to the camp counsellors. After two weeks, however, she began to violate the few minor restrictions in force at the camp, among other things, leaving camp in the evening to seek out the companionship of boys in neighborhood taverns. When her behavior was discussed with her she expressed regret but continued to act in the same way.

At this time it seemed likely that our evaluation of the home might have been overhasty. Before Hilda returned



from camp the family was given specific advice about meeting emergencies that might arise. So far as could be determined, the family was entirely coöperative in following suggestions. Shortly after Hilda's return home, however, she ran away again. She was discovered by the police in another city and brought home. At the time of her subsequent visit to the clinic she did not refer spontaneously to this episode. When she was specifically questioned concerning her truancy from home, she related the details without hesitancy, but could give no reasons why she had run away. She denied the occurrence of any precipitating episode in the home as a factor which might explain her behavior.

Following these events, Hilda was seen by the psychiatrist at weekly interviews. The most significant material which was revealed was the information that both in her day-dreaming and in her actual dreams she was frequently in a situation which left her unprotected against sexual assault by an unknown man. In spite of the fact that her actual dreams were often of a nightmare character, she stated that when she awoke she felt annoyed because her awakening came just "when something was about to happen." She also admitted feeling some antagonism toward her mother who, she said, tried to dress her as a younger girl than she actually was, while her own desire was to appear "like a siren." During this period, which was interrupted by a brief truancy, her behavior at home became quite unreasonable, so that finally the patience of her family was exhausted. Hilda described the scenes at home as "brawls" during which her mother struck her, threw her down, kicked her, and accused her of numerous types of degradation. She stressed the fact that her mother had never acted in this way before. An interview with the mother verified this description of the home situation. The clinic staff considered this state of things too difficult for Hilda to cope with, especially in view of the

fact that during the psychiatric interviews she was disclosing material that was itself disturbing to her. The psychiatrist suggested that arrangements be made for temporary foster home care. Hilda was reluctant to leave home, stating that she would be too lonesome and could never be happy elsewhere. At that time she seemed to have considerable understanding of what was at the root of her difficulty. While the deeper significance of her behavior was still obscure, she accepted the concept that unconscious drives and conflicts were the underlying motives for her acts. It was arranged with her that if she felt the strain at home becoming too great, she should come to the clinic and immediately other plans would be made for her. Three days after this interview she again ran away.

She was gone for three months, this time, earning her living as a tavern hostess. After a quarrel with one of her fellow employees she was discharged. She finally returned to the neighborhood of her own home, and due to the rather obvious, clumsy means she used to avoid her family she was discovered by her father. She agreed readily to his suggestion that she return home. During the next two weeks she stayed away from home overnight on three different occasions. The family did not feel able to assume sole responsibility for her any longer, and they took her to the Juvenile Court Detention Home. Now the immediate future of the case depends upon whether the court authorities feel justified in risking a further trial of Hilda left at large in the community or whether for her own protection institutionalization seems necessary. Institutional resources for meeting this type of problem are limited. Any punitive measures, if resorted to, would probably aggravate the situation, as can be inferred from the results with Hilda when such measures were previously tried. An institution which would afford the opportunity and facilities for treatment of psychotherapeutic

nature would, on the other hand, probably be of real value as a contribution toward her ultimate adjustment. But such institutions are not, at this time, available for the handling of juvenile delinquents.

**Discussion.** There were certain features in Hilda's background that suggest reasons for her difficulty in making a satisfactory adjustment. Over-strict parents with old-world standards in a new-world community, a younger sister with whom she competed unsuccessfully, limited resources for recreation, mental development running in advance of her physical growth and social experience—all of these are factors which could have serious repercussions on any child. However, to these problems Hilda found a fairly satisfactory "solution." She often described with evident pleasure the old-world customs that were kept up in her home, contrasting the enrichment this brought into her home life with her knowledge of other homes. She spoke with considerable understanding and seeming tolerance of the problem of her family's adjustment to American standards. She shared with her family aesthetic interests that she did not find in her associates. Yet even when she was given an opportunity to go to camp where her recreational and social needs were apparently satisfied, her behavior soon fell into a pattern similar to that exhibited at home. After a period during which she gained insight into her relationship with her sister, both her words and actions suggested that henceforth she would be able to make a successful adjustment. What can we say? Possibly the home conditions were such immediately prior to her truancy that they could be considered to have occasioned her behavior. But why, after her extended period of contact with the clinic and her apparent acceptance of it, did she fail to seek the help that she had reason to expect would be available there? Her own explanation for her conduct at all times has been that "a part" of

her acted in this fashion and the "other part" did not understand this behavior and could not control it. After four months of weekly interviews with Hilda, the psychiatrist is inclined to accept her own statement that she knows of no reason for running away which could be formulated as a conscious motive.

Her unfortunate experience at the age of eight should not be overlooked in the search for causes of her irrational conduct. However, the history definitely indicates that her maladjustment manifested itself long before that time. It would appear that some factors other than environmental ones must be included in any interpretation of this child's problem.

Cases like the foregoing are seen not infrequently in a child guidance clinic. The following example presents a rather different picture from the standpoint of the actual delinquencies, but raises the same question as to its causative factors.

### James

James was a large, gangling, coarse-featured, unprepossessing adolescent boy of dull intelligence. He was one of a large family, all of whose members had been in trouble at one time or another. His father, a heavy drinker, had finally been committed to the State hospital, where he died of paresis. During James' early life his mother, whose conduct was, according to the social worker, "questionable," worked to support the family while the smaller children were under the care of an older and unreliable sister.

James early became a problem, both at home and at school. He engaged rather steadily in minor delinquencies but avoided major crimes. When examined at the Institute he displayed almost no emotion toward any subject. When asked what kind of work he would like best he said, "It



don't matter what kind of job I get, just so I get one, but I don't like anything very long. I get tired in a little while and then quit and do something else," and then added cheerfully, "Guess I'm lazy, that's all." He said that his chief interest was making mischief. For example, he told of placing a broom in a doorway so that everyone who entered would trip over it. He called this plan "an invention." He denied that he ever felt badly or worried about anything in particular.

After the interview he was observed walking aimlessly about the clinic, entering offices without knocking and creating a disturbance in the playroom. At that time the psychiatrist formulated the following summary:

So far as could be determined this boy is entirely devoid of ordinary human emotions such as affection and sorrow. It appears that his only source of pleasure is making trouble for his family and the community and he takes a distinct pride in the success of his efforts in this direction. He is surprisingly frank in his disclosures of delinquent behavior, possibly because of the pride he takes in it. The apparent absence of accepted social feeling may, to some extent, be due to environmental circumstances such as frequent placements in correctional schools, yet the impression is received that this does not explain the whole picture and that something fundamental is lacking in his personality make-up. Because of the attitude described above, it is our impression that this boy is distinctly a menace to society.

During the years immediately following his examination at the clinic, intensive social treatment was attempted without apparent results. He was arrested several times, on one occasion for throwing bricks from the top of a building to the sidewalk below. Our last report concerning him was a letter from the Boys' Court stating that he was being held for larceny.

James presents in some respects a contrast to Hilda. The



social adaptation, however superficial, of which Hilda was capable and which she made, is lacking in the pattern of this boy. On the other hand, there is an underlying similarity; both children failed to establish satisfactory interrelationships between their own personalistic needs as separate individuals and their positions and functions as units in the social structure. Both are seeking something, the nature of which they themselves cannot define. Hilda apparently sought it by flaunting her defiance of her family and running away, while James sought it in a manner which superficially might be interpreted as an attempt to gain attention, something he was able to do successfully only by giving trouble. An attempt was made to facilitate Hilda's adjustment by supplementing the interests with which her life was inadequately provided. James was treated by rewarding with attention his favorable behavior and by providing a means for a more complete filling out of his time with socially acceptable activities. In the case of both children there is no indication that at any time their primary outlook on life changed in any way.

**Discussion.** One has the feeling that both of these children have remained as uninfluenced by their contacts with psychiatrist and social worker and changed surroundings as by the constructive values of their worlds in general. It is difficult to account adequately for the behavior of such children solely in terms of what happens immediately around them. It appears probable that the explanation is to be sought rather in the effect of experiences upon personalities whose make-up is constitutionally inadequate in some way not yet clearly defined. While the individual episodes of behavior are not widely deviant from those we see in many children, the total picture is more bizarre and not so easily accounted for or rationalized in terms of our present knowledge of mental mechanisms in children. Their behavior deviations seem to

follow a pattern not reasonably proportioned to their apparent conflicts. This is, of course, in keeping with the experience that changing the external conditions of life for such children does not bring the modification of their behavior which might be expected. They are, for some reason, unable to bring constructive intelligence to bear upon the problems of their adjustment to fundamental reality. While much of their behavior (as in the case of Hilda) may suggest that in some ways the individual is mature and socialized, there is left over a great part of it unintelligible in rational terms. They are singularly unable to formulate or to bring before the bar of conscious scrutiny material which could explain their aberrant behavior.

The rehabilitation of this type of child is still an unsolved problem, in the face of anything the child guidance clinic can do. To what extent more intensive and deeper probing psychiatric exploration, such as psychoanalysis purports to offer may prove the solution to these problems it is not within the field of this book to discuss. Until, however, a large number of these children have been thoroughly probed by such techniques, it should not be rashly assumed that they are crippled by a constitutional defect which from the outset makes their satisfactory adjustment in the community impossible.

### Frieda

Frieda, aged five years and three months, was referred to the Institute because she had extreme fits of temper during which she would scream, stamp her feet, throw herself on the floor, tear her hair, and bang her head. She had exciting dreams during which she talked aloud. She would tease and interrupt the play of her older brother and younger sister, and would aggressively attack members of her family and children in her neighborhood by striking, biting, and kicking

them. The attacks occurred in response to the slightest provocation, or even without provocation. She would obey no one and exhibited respect for no one. She constantly stole, begged money from men on the street and used profane language.

Frieda was one of three children. Her parents were Swiss. They were people of limited education. Her father was a laborer and the family lived in the basement of a tenement.

According to the mother the problem behavior had developed a few months before Frieda was brought to the clinic and at the outset consisted of dragging furniture over the floor. Previous to the development of this behavior Frieda had been attending kindergarten and there had been no unusual difficulty with her behavior either at home or in kindergarten. After the problem behavior developed the family had moved to their present neighborhood at the request of their landlord who lived downstairs. The foregoing behavior ceased and Frieda began to steal.

Physical examination of Frieda was essentially negative except that her nutrition was rather poor and the reaction of the pupils to light was sluggish. The pupillary response to accommodation was normal. The examination could not be very satisfactorily conducted because of constant crying and screaming.

A Stanford-Binet intelligence test showed Frieda to have a mental age of six years, which, divided by her chronological age of five years, three months, gives an intelligence quotient of 114, classification superior.

Frieda's parents appeared to be using poor methods for controlling her. Their training consisted largely in spasmodic and inconsistent punishment. The forms of punishment used included strapping, beating, confinement in a dark room, and tying her hand and foot to a rocker. The parents refused to consider placing Frieda in a boarding home and treatment

was therefore attempted at home. Since the coöperation of the parents was poor, the social worker devoted a good deal of time and intensive effort to the attempt to train Frieda in obedience. Authoritarian methods of training, out of keeping with present-day general practices, were given a prominence in the treatment of this case. Increased hours of rest were recommended and evening baths at a temperature of 98 to 102 degrees for their soothing effect. Frieda was referred to a medical clinic for the correction of her malnutrition.

Prior to her visit to the Institute Frieda had been excluded from kindergarten after she had attended only a few days, but she was reinstated at the request of the Institute social worker. She remained throughout the year in this school, receiving frequent school visits by the worker. The succeeding autumn the school again refused to take her and she was entered in a parochial school, but after three days she was expelled as disturbing and incorrigible. Six months later she was enrolled in another public school but was transferred after two and a half weeks to the one from which she was first dismissed. After a month's trial in this school she was placed in kindergarten because the routine there was less rigorous. She was expelled after two months. There were daily temper spells and constant stealing. For example, she would steal brooms and mops from neighbors and from stores and sell them for a few pennies. She would stop trucks and street cars by standing in front of them, refusing to budge until the drivers got out to chase her away.

Frieda's conduct was considered so serious that observation at a psychopathic hospital was recommended. Here a diagnosis of psychopathic personality was made and commitment was considered. At the instance of a physician of the psychopathic hospital, however, Frieda was instead placed through the Juvenile Court on a dependency petition.



First she was placed in a children's home for ten days. At the end of this time an attempt was made to place her in a private boarding home. When she met the boarding mother she burst out with such a tantrum that the boarding mother refused to accept her. After being returned to her own home she was placed in the receiving home of a child placing agency with the idea of attempting another placement in a private home. She remained in the receiving home for one month during which time she attacked other children, screamed a great deal at night, pilfered from nurses' dressers, and had on the average three temper tantrums daily. At the end of the month the child placing agency refused to carry the case longer. She was transferred to the Juvenile Detention Home where she remained for a month. Further efforts were made to place her in a boarding home, but the court was unable to secure a home which would take her. She was therefore returned to her parents. Then she was reëntered in parochial school and continued on a modified schedule of half-day attendance for five months.

By this time the typical characteristics of Frieda's behavior were so evident as to suggest a probable explanation, and a careful review of all aspects of the case was undertaken. It was revealed that the patient's abnormal behavior began at the age of four and a half years in the spring of 1920 following an illness diagnosed as influenza. The symptoms related by the mother were symptoms typical of lethargic encephalitis.\* After this sickness Frieda could not play with the Italian children in the neighborhood without continually fighting, whereas previously she had played with them quietly. A re-examination of the child with this diag-

\* At the time of Frieda's original examination at the clinic, lethargic encephalitis was still a relatively newly recognized disease and its rôle in producing behavior disorders was inadequately understood. Consequently there had been no attempt to go back of the recorded diagnosis of influenza.



nosis in mind disclosed nothing further of significance except that the original detection of sluggishness in pupillary response to light was confirmed and it was noted that the hymen was perforated. (It was learned that there was frequent masturbation.) On the basis of the history and the behavior, a diagnosis of "post-encephalitis"\* was made. During subsequent physical examinations over a period of nearly fifteen years from the time of the first contact, there has been little physical change other than the normal processes of growth. At the last examination the pupils were small, slightly irregular and reacted but very slowly to accommodation. There was a slight weakness of the movements of the right lower face, and marked coarse tremor of the tongue, huskiness and slight slurring of speech.

Almost simultaneous with the diagnosis there was a recurrence in a milder form of certain symptoms which had appeared in the original illness. For two days the child complained of seeing double when reading or looking at small objects. For a week she complained of being tired and would bump into things as she walked about. She explained that she felt drunk. She slept thirteen hours at night and sometimes for a part of the day. Immediately following this the mother reported that the patient acted "like crazy." She ran into an alley when forbidden and when brought into the house by force she had a temper tantrum lasting two hours. She dashed into the pantry and tried to seize a knife screaming, "I'll kill myself." Following this she was drowsy for two weeks. Frieda was eight and a half at this time.†

After the diagnosis of encephalitis was made, more effort

\* It is now recognized that what was formerly diagnosed as "post-encephalitis" is usually chronic encephalitis rather than a sequel of a past infection.

† This second period of illness with double vision and drowsiness probably represents a minor flare-up of a chronic encephalitic infection. Such exacerbations are not rare in chronic lethargic encephalitis.

was directed toward "padding her environment" and toward persuading those about her to be tolerant and to overlook her trying behavior because it was now realized that she acted as she did because she was ill. Effort was also directed toward providing her with interests which would give her some satisfactions.

**Discussion.** The succeeding history of the case is a story that appears, in retrospect, as a record of years given over to heroically patient efforts at social treatment, rewarded only by very slow and decidedly jagged improvement in behavior so far as the temper outbursts and combativeness were concerned. Some simplification of the problem resulted from diminished frequency of the temper outbursts, but this was partially offset by difficulties due to the girl's increasing strength and power of resistance. She returned to public school, was transferred, then placed in a subnormal room, then expelled, later re-admitted by a new principal at the request of the Institute, and again re-expelled when she had a tantrum and created an uproar which resulted in her being carried off, kicking and screaming, by two policemen and a patrol wagon.

All available social resources were repeatedly canvassed and much fruitless effort expended. Several camp placements were arranged. Frieda was admitted to a public school for crippled children, but they reported that she required the entire time of one teacher and refused to take responsibility for her when it was not found possible to have an adult take her to and from school. She was committed to a private institution for delinquent girls where she was enrolled in an industrial class for eighteen months. Under this routine she steadied somewhat. Discharged, she attended public school, finally completed the eighth grade, and then entered a public vocational school. When sixteen she began to work spasmodically whenever she was able to secure employment

in factory work, housework, peddling from house to house, and crocheting.

Fourteen and one-half years after the original examination of Frieda the case was re-opened as the girl was referred by a social agency for the protection of children. She had been picked up by the police at an amusement park grounds where she was begging cigarettes from men. Frieda had been employed as a dish washer at the amusement park but was required by her father to give up the job because she started work late at night and did not finish until morning. She later obtained work selling doughnuts but was discharged because she ate too many. For a short time she was employed as a model at a museum displaying torture equipment. The exhibit was discontinued after she had been employed a week. Then she began selling soap and notions from door to door.

She appeared unhappy in her social situation. Her family was now living in a neighborhood inhabited predominantly by negroes, and she objected to this and complained over her lack of friends. It was arranged to introduce her to a group interested in dramatics at a neighborhood social settlement, and for a time she appeared to be making a satisfactory adjustment and to be getting adequate satisfaction from her work in the group. After a few months' time she broke off her contacts with this settlement and the Institute has not yet heard from her again.

During the period of observation Frieda was given seven intelligence tests. Her I.Q. ranged from a maximum of 114 in 1921 to 90 obtained in 1926. The last rating (obtained in 1934) was 108. There can be no question of the adequacy of the girl's intellectual equipment.

Nearly fifteen years have elapsed since the illness which first created a serious behavior disorder. During that time much improvement has occurred. Frieda has at least been

able to remain at large in the community during most of that period. Her irritability no longer presents as severe a problem. She no longer constantly loses control of herself in emotional outbursts. She remains, however, a restless, distractible, undependable, scatter-brained girl, utterly lacking in stability and social judgment.

The type of intensive long-time social treatment exemplified here illustrates the only present alternative to institutional care for many children with marked encephalitic behavior disturbances. The results are usually meager for the effort expended, but they are by no means entirely fruitless and discouraging. By dint of untiring effort and unwearied patience even some of the more severe cases may be rehabilitated to a point which makes their care in the community possible.

Other aspects of the treatment of children who are the unfortunate victims of this disease have already been considered in Chapter VI.

Perhaps one reason that Frieda has remained in the community is that during the period in which the Institute struggled with her there was no suitable institutional placement available. The girl was not feeble-minded, insane, epileptic, blind, deaf, or orphaned. The only type of institutional placement available would have been in a correctional school for delinquent girls—a manifestly unsuitable placement. In recent years in many States arrangements have been worked out so that legal steps make institutional care available for encephalitic children and adults who are in need of it.





PART IV

THE CLINIC AND THE COMMUNITY



## Chapter XV

### THE RELATIONSHIP BETWEEN THE CLINIC AND THE COMMUNITY

UNTIL 1909 but little progress was made in the application of science to the understanding of children's behavior problems. Psychiatry was still in the throes of the attempts to classify mental diseases and evinced signs of only just beginning to realize the significance of the motivation of behavior. It was absorbed in the description of syndromes and had not yet achieved as working instruments the many important dynamic concepts which are now regarded as fundamental to the theory and practice of psychiatry. A relatively static point of view predominated in nearly all investigation of deviations in conduct disorders. This was true not only in the study of adults, but also in the study of children.

With the inception of the juvenile court movement a newer methodology for the treatment of dependent, neglected, and delinquent children was introduced. The court was primarily concerned with finding solutions for the problems of children, and from its beginning has employed all the existent social work techniques. In 1909 the Juvenile Court of Cook County introduced the psychiatric approach when it established the Juvenile Psychopathic Institute, which was at first privately supported. Seven years later the clinic was taken over by the State of Illinois and became known as the Institute for Juvenile Research. Since then its work has extended into the general community of Chicago and throughout the State. In the work of this organization and others

of its type and through the thinking and efforts of their staffs much of the present-day philosophy of the child guidance movement has been developed.

During the first seven years of its existence the Institute, under the direction of Dr. William Healy, gave most of its attention to the problems of children brought before the Juvenile Court. The policy was broadened in the second seven-year period to include an increasingly large number of cases referred from other sources in the community. Among these were many from family agencies, child placing agencies, and agencies concerned with health, as well as from the public schools and from parents. The Institute for Juvenile Research was thereby able to broaden its point of view and approach. As a result of this policy children with a great variety of behavior difficulties found their way into the clinic. The early referrals were made up largely of the more severe conduct disorders frequently associated with economic dependency and mental deficiency.

As other agencies availed themselves of the service of the Institute the types of problems showed a pronounced change. Children were brought in at an earlier age, with their patterns of behavior less fixed. Other changes in kinds of cases referred came about as the years passed. A gradual decrease in the proportion of children from the court occurred, though there was no reduction in the actual number of cases. An increased demand for service was met by the establishment of a second clinic which ultimately became the central clinic and headquarters. Children referred by the juvenile court who were not to be institutionalized were examined at the headquarters clinic. The others were studied at the branch clinic housed in the juvenile court building. Establishment of the second clinic made possible the acceptance of more cases from social agencies, principally from family welfare agencies.

The early period began with the social agencies as its chief source of cases. At the end of the second seven years the number of the cases referred by the various community agencies and institutions to the headquarters clinic is shown in the column for the year 1924.

TABLE I

# PERCENTAGE OF CASES REFERRED FROM VARIOUS SOURCES BY YEARS

	1909	1916	1924	1931	1934
<i>Juvenile Court</i> .....	100%	25%	15%	18%	14%
<i>Social Agencies</i> .....		75%	54%	24%	23%
<i>Parents and Other</i>					
<i>Relatives</i> .....			17%	30%	25%
<i>Schools</i> .....			6%	19%	27%
<i>Health Agencies</i> .....			6%	7%	9%
<i>Physicians</i> .....			2%	2%	2%
Total .....	100%	100%	100%	100%	100%
Total Cases .....			1,158	933	1,560

During the third seven-year period the proportion of cases from schools was tripled and that from parents was doubled; there was a corresponding reduction in the proportion from social agencies. The latter decreased by more than one half.

Although there has been a gradual change in the activities of the Institute for Juvenile Research in the years of its existence, it has maintained a threefold function: first, the continuous study of children's problems from the research point of view; second, service to the child and to the community through its diagnostic and therapeutic work; third, the dissemination, through its educational program, of



knowledge gained through the study of individual cases and through special research projects.

Because of the growing realization that behavior difficulties in children are frequently dependent upon maladjustments dating to years before social contacts are made through school life and other activities, special facilities were set up to make possible the study of this younger age group. This was effected through the organization of a preschool service which permitted considerable departure from the techniques used in the preadolescent and adolescent groups.

Although the extension into the community was brought about by the establishment of a separate central clinic, the investigation of behavior difficulties of children coming before the juvenile court continues. In the juvenile court branch a more highly selected group is available for study. The staff assigned to this work functions as a complete unit and is concerned primarily with children referred for rather serious delinquencies in which mental deficiency is often a related problem.

In addition to the setting up of a central clinic other extensions into the community have been brought about. Two neighborhoods within the city of Chicago, varying greatly in their cultural aspects, were selected for study. These communities differed in that one had an exceedingly high rate of delinquency and the other, in a more distinctly residential community, had a very low rate and was fairly representative of the average urban American community. Part-time clinics based on the general plan of the one at headquarters were organized. Within these two branch clinics an opportunity was afforded for the study, through cases, of the social and individual factors influencing behavior at the point of its development.

As the towns and rural communities in Illinois awakened to the need and value of studying the problems of children,

they asked for help. The first requests followed a survey of the handicapped children in a mixed rural and urban community in central Illinois. This survey resulted in the establishment of the first visiting child guidance clinic. These clinics have increased in number and spread over almost the entire area of the State. They permit of a more intimate study and appreciation of influences causing behavior difficulties in the rural communities. The activities in these clinics have permitted the staff of the Institute to realize more clearly the differences in the urban and rural influences.

Every State in the country accepts responsibility for certain of its child citizens. In Illinois these wards of the State fall into five general categories: the mentally handicapped children (mentally defective children, epileptic children, those with encephalitis, or other organic brain disease), children found delinquent by the courts, certain dependent children (chiefly orphans of Illinois soldiers and sailors), the deaf, and the blind. Each of these groups is cared for in special boarding schools or institutions. Through the organization of the Department of Public Welfare the Institute staff renders service to these institutions and has an opportunity to make intensive case studies of the children in them and to develop research projects in connection with these studies. The Institute staff has also been called upon to advise these institutions in the care and training of children. The new recreational and educational program for the mentally deficient is an example of this working relationship. In addition to the work carried on in institutions under the management of the State, private boarding schools for dependents and mentally deficient children under private auspices have also permitted the conduct of investigations and further studies.

Beginning about 1926 the Director of the Institute for Juvenile Research was able to interest a group of private

citizens in the need for a more intensive research program in which qualified research workers would be free to pursue their research without being hampered by service duties. A considerable sum of money was contributed to a Behavior Research Fund which permitted the development of a variety of research projects more or less directly related to the behavior problems of children. Staff personnel was brought together and the set-up was continued until 1931. A large part of the results of their work has been published \* in the following books:

- Brain Mechanisms and Intelligence* by Karl S. Lashley  
*Delinquency Areas* by Clifford R. Shaw  
*Order of Birth, Parent-Age and Intelligence* by L. L. Thurstone and Richard Jenkins  
*Children's Behavior Problems* by Luton Ackerson  
*The Jack-Roller* by Clifford R. Shaw  
*The Natural History of a Delinquent Career* by Clifford R. Shaw  
*Growth in Private School Children* by Horace Gray and J. G. Ayres  
*Studies in the Dynamics of Behavior* by Chester W. Darrow et al.  
*Behavior Mechanisms in Monkeys* by Heinrich Klüver  
*Children Who Cannot Read* by Marion Monroe  
*Lying and Its Detection* by John A. Larson  
*Children of Preschool Age* by Ethel Kawin  
*Play Behavior and Choice of Play Materials of Preschool Children* by Dorothy Van Alstyne  
*A Comparative Study of a Nursery-School versus a Non-Nursery School Group* by Ethel Kawin and Carolyn Hoefer  
*An Experiment in Recreation with the Mentally Retarded* by Bertha Schlotter and Margaret Svendsen

\* These books were published for the Behavior Research Fund of the Institute for Juvenile Research by the University of Chicago Press, Chicago, 1929-1935, except the two by Schlotter and Svendsen which were published privately by the Fund.

- A Handbook of Games for Play Leaders and Teachers* by  
Bertha Schlotter and Margaret Svendsen  
*Social Factors in Juvenile Delinquency* by Clifford R. Shaw  
*The Physical and Mental Growth of Prematurely-Born Children* by Julius Hess, George Mohr and Phyllis Bartelme

As a direct result of such quantitative studies of the distribution of juvenile delinquency as Clifford Shaw's two volumes, *Delinquency Areas* and *Social Factors in Juvenile Delinquency*, the need for a more intensive investigation of the causes, treatment, and prevention of juvenile delinquency was made evident. To further such an investigation the Institute interested a number of professional men and civic-minded residents of the community in forming a corporation, known as the Chicago Area Project. The program of research and service was developed, directed, and partly financed by the Institute; but in a large measure was financed by private foundations and contributions from local agencies. This program aimed at a further study of the causes of delinquency in three areas with a high delinquency rate, and at working out a neighborhood plan of treatment for juvenile offenders. The program is being carried through in coöperation with existing agencies. Individual studies of delinquents are in progress, the facilities already available for shaping the behavior of children are being coördinated, and the development of further facilities for doing this stimulated.

About 5,750 children receive service at the Institute yearly. Of these about 1,500 are new cases, and 3,000 are old cases. In the branch clinics about 1,000 children are studied yearly; in the community or visiting clinics, about 250.

In order that various agencies may have access to the services of the Institute for the continuous treatment of children, arrangements have been made for the assignment of an Institute staff member to work in close coöperation with



each agency. This permits the staff worker to become more familiar with the program of the agency, and at the same time the agency is kept constantly informed in respect to the changing needs in treatment. Furthermore, the arrangement provides for the study of children beyond the clinic examination.

The visiting clinic program of the Institute has certain features which should be specially mentioned. The request for the services of the Institute initiates with the local community and the Institute's activities are therefore free from paternalism. Whatever influences may be operative in awakening a realization that the local community needs service, the decision to request that service must come from the community. The Institute asks that three or four large groups in each community be in accord in their request for these services before a clinic unit is sent to a community. These organizations include in the main the social agencies, schools, and medical and religious groups. When these various agencies are in agreement as to their need the Institute responds and formulates working relationships and standards of personnel and service. Because of the importance of having a permanent service in the community, one of the local agencies assumes responsibility for the visiting clinic. It is understood also that the clinic services are to be educational as well as directly helpful.

Because this point of view is adhered to, the selection of cases includes a wide sampling of children's problems. Also the extension of the program into the community life is promoted. In so far as professional personnel is already available in the local community, it is the understanding that it will be utilized. This includes specifically medical and social services. Written reports of examinations in these two fields are required and become part of the completed record. Usually, children selected include those for whom adequate



local facilities and diagnosis are not available and for whom a remedial treatment program is feasible.

Upon completion of these arrangements the time for a visiting clinic is set. Three members of the Institute for Juvenile Research staff take over their respective functions in that community for the period of the clinic. These include a psychiatric social worker, a psychologist, and a psychiatrist. Since all communities already have adequate medical services available, the fourth member of this team is one of the local physicians. The group functions in the same manner as at the clinic at headquarters. These clinics are held at intervals, depending upon the conditions which exist in that community. Usually they are for a period of three continuous days at two-month intervals throughout the school year. The sponsorship of the local clinic varies greatly. In the main it is carried by social agencies, perhaps a family case work agency, perhaps a child placing agency. In several communities the schools sponsor the clinic. The stenographic, clerical and administrative duties are provided by the local community. Responsibility for continuity of treatment is assumed by the local professional workers. The additional expense incurred by the staff of the Institute in travelling, too, must be borne by the community.

In keeping with the policy of freedom from paternalism the program provides for the withdrawal of the Institute service as soon as the local community is able to provide such specialists as psychiatrist, psychologist, and psychiatric social worker. No definite time is set for the completion of this separation, nor is there a definite order for terminating the services of the personnel. In general, when the local community is able to provide a psychiatric social worker, this member of the staff is chosen as the first to leave. She is usually followed by the psychologist, and ultimately the psychiatrist is replaced, in plan at least. In the twelve local

community clinics complete withdrawal has occurred in only one instance. In several of them only the psychiatrist continues his service; in others the psychologist continues to function, and in the newer ones all three members of the staff continue their services.

In addition to the usual clinic service the staff participates in the deliberations on extending the services locally, conducts classes for the professional workers, and gives lectures to the lay public dealing with the general subjects of child guidance and mental hygiene.

A teaching program has been developed for professional workers; this includes special training for teachers in the interpretation of the child guidance point of view, and also demonstration clinics and lectures for under-graduate students and lay groups interested in the principles of mental hygiene and child guidance.

For a number of years the Institute has served as a field training center. Students in psychiatric social work are taken on for supervised field training from each of several schools of social work, including Smith College, the University of Chicago, Northwestern University, and Loyola University. In addition to these students, others in the field of sociology are accepted for a period of training. The standard of this training is determined by the Institute in coöperation with the universities. The Institute has insisted that the standard of training be high, in view of the tremendous responsibility involved in regulating and influencing the lives of other human beings. This training is comparable to that given the physician in the course of his internship. A minimum period of six months is required for workers who are planning to devote themselves to the field of psychiatric social service.

In the field of psychology the training of personnel for the more distinctly clinical aspects has for a number of years been recognized and provided. Universities are rarely

equipped to offer field training in these branches of psychology, and the Institute service is an adjunct of the universities. A definite program is established providing for a minimum of six months' full-time supervised training. A limited number of students are accepted and the training is organized to meet their needs. Universities accept such training for graduate credit and the demand for it has increased rapidly. In training at the present time are students from the University of Illinois, the University of Chicago, Northwestern University, the University of Minnesota, and Stanford University.

An organized training program is in effect, also, for physicians preparing for the field of psychiatry. Students come for a period of two years' full-time training. On completion of their training they are eligible for psychiatric service and practice with children. This training may be counted for university credit. Because of the longer period required for this training a stipend is paid these students.

In addition to these more formal kinds of training, professional workers desiring training and experience in limited phases of the Institute's work are accepted, especially teachers who desire to add to their professional equipment special techniques such as those used with cases of specific reading disability. These pursue courses in remedial instruction in reading, limited to thirty-five teachers.

Physicians come for part-time training so that they may better apply the principles of mental hygiene in their general or more special practice of medicine, as the case may be.

Staff members are assigned to teaching outside their specific duties in the clinic. In each of the four Class A medical schools in Chicago, members of the Institute staff conduct courses and take part in the development of services for children. Members of the social service and of the psycho-

logical service are conducting classes in the graduate schools of several universities. In one teacher training college the Institute staff is conducting not only a demonstration clinic but short lecture courses as well.

From time to time the various agencies dealing with children, such as the child placing and public health agencies and the scholarship associations, have requested lecture courses. These are developed to meet the specific needs of the workers in dealing with the children under their care.

PART V

PERSPECTIVE





## Chapter XVI

### PERSPECTIVE

THE child guidance field is, in many regards, a field of confusion, criss-crossed by indefinite but jealously guarded professional boundaries. Had our organization of the divisions of professional work grown up about the field and the problems of child guidance, it would, perhaps, have been a very different one. However, a profession is not created overnight, nor yet in twenty-five years. We build on what we have. Society, like any other growing organism, shapes the new from the old. The coöperative attack of workers converging from different but related professional fields on the problems of child behavior was a logical and well-advised move calculated to bring more knowledge and skill to the problem than was any other course.

The coöperative approach has its strength and its weakness. Its weakness is its complexity and the cumbersomeness of the organization required. As a result it is relatively more expensive, and it requires of its staff a greater degree of coöperativeness and team work than would a more individualized organization. Its strength lies in the fact that it brings to the problem a breadth of view possible only from the interplay of diversely-trained minds, and in providing natural liaisons between the several professional groups (social workers, teachers, physicians, recreation leaders) which must be enlisted in any effective attack upon children's problems. From this point of view there is some advantage in the constant schooling the staff members receive as they work shoulder to shoulder with others. This is a

field in which a rigid or authoritarian type of organization is impossible; genuine coöperation is necessary and an elastic and coöperative attitude must be developed.

The foregoing chapters have, it is hoped, illustrated the diversity of forces which may shape a child's behavior, the diversity of "causes" which may produce a given behavior symptom, and the diversity of effects which a given factor or force may produce, depending upon the "set" of the child and all the other determining conditions in the situation.

Treatment may often be confined to a direct and admittedly superficial effort to modify or remove a particular behavior manifestation. Frequently such treatment is all that is required, and the effort to probe deeply into the child psyche may be unwarranted or even unwise. Sometimes it will be necessary to rearrange the life of a child so that thwarted drives find a more normal expression before a behavior symptom can be modified. It may in turn be necessary to aid parents to solve their own emotional problems before such a rearrangement is possible. It is in general good therapy as well as good sense to begin treatment at the simplest level at which it is likely to prove effective. The probable future course of things as well as the present problem must receive consideration in formulating the strategy of attack.

The clinic is able to surmount some of the handicap of its disadvantageous and expensive complexity by sorting its cases and omitting special examinations in those cases in which they do not seem especially indicated. In view of the financial burden it would entail if clinics were made available everywhere, however, it is manifestly more than unlikely that child guidance clinics can be so multiplied in the visible future as to be capable of taking care of all the children who are in need of such service.

What then is the justification for the child guidance clinic and how may it best fulfill its potentialities?

The *raison d'être* of the child guidance clinic is the blazing of a trail and the setting of a standard. It acts as a common link and channel of knowledge between the various groups and organizations which treat children's behavior.

The organization of a child guidance clinic, with its pooling of techniques and viewpoints, provides a rich substratum for the growth of knowledge and skill in the field. The concentration of attention, the assembling of techniques, the availability of different skills, all contribute to the production of a yeasty milieu, more encouraging of growth in child guidance than is the intermittent study of behavior problems by the family case worker or the pediatrician or the school psychologist. If the staff of a child guidance clinic fail to lead, it is because they are not taking proper advantage of the opportunities which are before them. This is not to say that they should not constantly be learning from others and transmitting what they learn on into the common stock of available knowledge and techniques. But it is their opportunity and their business to be at the forefront of their field. This obligation to lead in turn implies adoption of an attitude equally far from complacent satisfaction with the profundity of their present knowledge and the habit of constantly chasing every will-o'-the-wisp over the marshes. The basis of all the clinic attempts must always be common sense implemented with scientific knowledge and professional skill, but common sense none the less. In order to make possible the exercise of common sense in this field, as in any other, it is necessary to know the subject-matter well, to possess a long-continued and intimate acquaintance with children and their problems of adjustment, to have developed an ability to recognize the significant factors in a situation, and to think in terms of these factors.

How can the child guidance clinic best fulfill its potentialities? It must be a center of training, of study, of research, of exchange in ideas. It should provide training for workers in different professional fields who wish to improve their knowledge of the problems of child behavior. Here will gather the psychiatrist, the pediatrician, frequently the general practitioner, the social case worker, the visiting teacher, the remedial teacher, the recreation leader, the clinical psychologist, and probably others. Naturally the clinic must also provide suitable training for those who wish later to become members of its staff. As rapidly as new insights or new techniques are developed in the clinic they should be passed on to the other organizations capable of applying them. For example, it is highly desirable that the techniques of diagnosis and treatment of special educational handicaps, such as in reading or arithmetic, should be taken over as rapidly as possible by the schools. Certain of these techniques were developed largely in the child guidance clinic, but it is clearly the task of the school to take them over as a part of the techniques of education. This does not imply that the clinic should cease working with them, but it should be freed so far as possible from the vast service load of such work in order that its staff may concentrate on further creative contributions. To make such a transfer possible it must be prepared to train teachers in these techniques, and of course the school must be willing to make arrangements whereby such teachers can carry out remedial work. Some school systems have made arrangements for such special instruction to be given to children who need it.

That the program of treatment should have lagged somewhat behind other phases of the work is perhaps inevitable, since treatment is dependent upon the clarification of diagnostic concepts, and, moreover, formulation of treatment practices in this field is comparatively recent. Other factors,



however, have operated to hold back the treatment program of the child guidance clinic. Among the chief of these are lack of budgetary resources sufficient to retain the needed number of adequately trained therapists, the lack of suitable agencies in the community, and the lack of integration between the efforts of the various agencies and institutions now interested in child education and child welfare. As we become aware of these limiting conditions we are led to the conclusion that in the future the educational program of the clinic may need to be greatly strengthened, particularly in relation to the public schools, and that attention must be given to ways of adapting the individual treatment techniques developed in the clinic to groups of children, in order that larger numbers of children may be served.

From what has been said it can be inferred that the child guidance clinic needs to be interested in research. It will not engage in research to the exclusion of clinic activity—to do so would be to destroy its *raison d'être*, but it cannot fulfill its function unless it seeks to advance knowledge as well as skill, and the advancement of knowledge necessitates research. Though the research will be clinically oriented, as sufficient funds are available more basic or theoretical problems may be undertaken. One valuable by-product of an ideal research program that is often overlooked is the development of open-mindedness and of analytical and creative thinking, a by-product which is reflected throughout the whole clinic program and which aids in lifting it above the level of duties fulfilled through following a routine.

An intimate connection between a university and the child guidance clinic is logical and desirable if the latter is to realize its potentialities as we have outlined them. A child guidance clinic should function in an atmosphere not aloof or insulated from the rest of the community. It needs the enrichment of interchange with groups and agencies working

with children in other phases of their lives, and in particular, agencies working with normal children. Such interchange will enable its staff to avoid becoming oriented too narrowly with reference to the maladjusted child and too little with reference to children in general, a bias that has serious dangers. Such interchange should be valuable also to the other agencies not only in individual cases, but also in shaping their programs and policies.

This further suggests the need for members of the clinic staff to come closer to the community agencies which render other types of services to children. At the Institute this has been done to some extent in the past, through the assignment of members of the staff, on a full- or part-time basis, as examiners and consultants in schools, parent education groups, and social agencies. The final responsibility for extension and modification of existing facilities must probably rest with such organizations as the State legislature, the local government, the board of education, and the Council of Social Agencies, but the clinic itself needs to do its share in stimulating responsible groups to see the necessity for bringing about changes and extensions in educational and welfare programs.

For example, the Institute for Juvenile Research has found itself overburdened with two groups of cases in particular. Great numbers of feeble-minded children have been referred for examination because other community facilities have been lacking. These examinations have been administered for the purpose of routine commitment procedure in many instances, or if commitment has not resulted the lack of other community facilities for the care and training of the feeble-minded has rendered most of the alternative forms of effort in behalf of the feeble-minded futile. The Institute has also tended to accept numbers of delinquent children for examination for whom society supplies no adequate care,

either in institutions or in the community. Accepting such large numbers, even a preponderance, of such children for examinations at the clinic lays it open to the criticism that it has not recognized community responsibility for child guidance work and the limitations of child guidance work as it must be practised to-day. Perhaps the clinic should focus more attention on its "intake" policies, including here the constructive value of the rejection of cases, and take a rôle in the establishment of "consultative service" with other agencies and in the recognition of the social agency worker as the therapist.

There is implied in the suggestion that the clinic services be more closely integrated with those of other community agencies, the corresponding need for the clinic staff to gain more of an appreciation of the influences operating in local communities as they affect great numbers of children and to elicit wider community support for the continuation of its own services.

A change in the cultural patterns of a community may be necessary in order to effect certain desirable objectives, such as the control of delinquency. It is not the function of a child guidance clinic to seek to bring about such a change in the cultural pattern of a community or to reorganize the economic structure of society. An effort to modify the cultural pattern of a delinquent community may be set up in conjunction with a child guidance service, but it will of necessity follow a pattern of its own, quite different from that of the clinic. A clinic set-up may, however, be included in such a venture as an auxiliary.

It is the function of a child guidance clinic to aid children to make the best possible adjustment within the existing framework of society. Any service that does this will be valuable within any social organization. It should be careful not to let its functions be jeopardized by compromising polit-

ical alliances either with partisan politics or with class interests, since it has very little to contribute to such cases and much to lose by such tactics. It has an important and valuable function as an organization—a function for which there will be place and need so long as our social organization remains imperfect. Its smoothest and most productive functioning for its avowed purposes should not be risked by ill-advised diversion of effort to ends to which it is not adapted. In relation to its own work, the personnel of a clinic, however, is in a position to call attention from time to time to certain types of social and economic defects which act as causes of maladjustment or are obstacles to treatment.

The method of financing child guidance will doubtless be varied. Some aid will doubtless often be paid for directly by the parent. Care should be taken, however, to prevent this method of support from becoming so general that suitable aid is denied to children who need it, thereby damaging the community. It is a concern of the neighbors and of the community as well as of the parents if a child seems likely to become a sex pervert or an incendiary, and it is neither good policy nor good sense to deny aid because the parents cannot afford it, or believe that they cannot afford it. In these matters we must be realistic. A slight sacrifice to obtain aid often results in its being taken more seriously; a heavy sacrifice is more likely to mean that the aid is never obtained.

No one plan of financing the clinic is wholly advantageous. Public support has special hazards attached to it since there may be restrictions on the choice and tenure of staff workers which impair the effectiveness of the work. If this is not felt through specific political manipulations it may be felt through limitations of salaries, limitations which interfere with securing and retaining the best trained personnel. On the other hand, even when a governmental agency maintains consistent support, unless there is careful planning,



there is danger of stagnation in the organization through over-routinization. In such a situation it is extremely important that the clinic accept a definite place among community agencies on a "give and take" basis and be sensitive to the demands as well as to the development of the agencies.

The central clinic scheme sets certain limits on treatment due to its formal character and the usual distance from the neighborhood where the child lives, making frequent contacts impossible. If the intake is large in relation to the size of the staff, as is usually the case in a public-supported clinic, only a relatively small proportion of all the cases seen can be treated by the clinic staff.

One may finally ask how the needs of the maladjusted child are to be met in the future. It should be the goal to meet them in part at least by prevention of maladjustments. A broader program for the schools, parent education, intelligent organization to provide suitable recreational opportunities for children, the relief of home tensions such as have been created by the now passing but perhaps soon to recur economic crisis—all can make their contribution. In these areas measures of real mental hygiene can be taken. When the possibilities of mass hygiene have been realized there will still remain many problems of individual adjustment, which must be met individually. For example, any one with experience at a child guidance clinic can recall instances in which even well-informed parents still created problems in their children because of emotional attitudes which mere instruction could not remedy.

How then will these problems be met? Doubtless in a diversity of ways. The school will probably take a more active rôle in the future and increase the responsibility it is now taking for the child's socialization and adjustment. The school, however, does not come in contact with the child until he is five or six years of age and by this time many



problems are full blown. The very young child is, or should be, under the surveillance of the physician, and in particular the pediatrician, who will doubtless assume increasing responsibility for supervising the emotional as well as the physical health of the child. The family case worker is developing a dynamic understanding of family inter-relationships, which will no doubt become increasingly useful. Her work has in the past been largely confined to the economically dependent, but it is becoming less and less so. The psychiatric social worker is more especially trained to operate in the mental hygiene field and there is an increasing tendency to make available her services to that greater portion of the community above the level of dependency.\* The recreation center will doubtless become increasingly a therapeutic agency, a center of "play for play's sake" and yet for the meeting of special needs and the facilitation of difficult adjustments. The recreation leader is in a position of rare opportunity, if he is equipped with an understanding of children and their differences and individual needs, as well as with a knowledge of techniques of leadership in recreation. The clinic will remain as a center of investigation and training and as a court of appeal for difficult problems. Aside from the juvenile court, it will probably remain the chief agency concerned wholly or directly with the study of the causes and treatment of behavior problems. It would probably be advantageous, when funds can be secured, for the clinic to increase its service by setting up a simpler and cheaper type of organization away from its central head-

\* There has been a widespread tendency during the depression for private agencies, which in normal times carried many cases on what was chiefly a relief basis and carried other cases on a more complicated case-work basis, to shift the former to the public agencies and to accept in return cases in need of more intensive case work. This has resulted in a tendency for the case workers in such agencies to merge their viewpoint and the nature of their work with the psychiatric social workers.

quarters, a service in which all study could be concentrated in the hands of a single individual. This plan would be particularly suitable for smaller communities or rural areas which cannot afford a full clinic set-up. Such a venture must be regarded as an extension of and not a substitute for the more careful work of the clinic, which must remain its major contribution and justification.



## BIBLIOGRAPHY

### CHILD GUIDANCE

- Ackerson, Luton, *Children's Behavior Problems* (The University of Chicago Press, Chicago, 1931).
- Aldrich, Charles A., *Cultivating the Child's Appetite* (The Macmillan Company, New York, 1928).
- Blanchard, Phyllis, *The Child and Society* (Longmans, Green & Co., New York, 1928).
- Blanton, Smiley, and Blanton, Margaret, *Child Guidance* (The Century Co., New York, 1927).
- Burling, Temple, "The Value of Explicit Acknowledgment of the Transference," *American Journal of Orthopsychiatry*, IV, 1934, pp. 518-523.
- Cady, Bertha and Cady, Vernon, *The Way Life Begins*. (The American Social Hygiene Association, New York, 1928).
- Elmer, M. C., *Maladjustment of Youth in Relation to Density of Population* (Publication of the American Sociological Society, 20, 1926, pp. 138-140).
- Hall, G. Stanley, *Adolescence* (D. Appleton and Company, New York, 1928).
- Hart, Bernard, *The Psychology of Insanity* (The Macmillan Company, New York, 1929).
- Healy, William, *The Individual Delinquent* (Little, Brown and Company, Boston, 1929).
- Jenkins, R. L., "Adoption Practices and the Physician," *Journal of the American Medical Association*, 103, 1934, pp. 403-408.
- Jersild, Arthur, *Child Psychology* (Prentice-Hall, Inc., New York, 1935).
- Kawin, Ethel, *Children of Preschool Age* (The University of Chicago Press, Chicago, 1934).
- Piaget, Jean, *The Language and Thought of the Child* (Harcourt, Brace and Company, New York, 1926).
- Richman, John, *Bringing Up Children*, A Symposium by Five Psychoanalysts (Kegan Paul, New York, 1936).

- Schweinitz, Karl de, *Growing Up* (The Macmillan Company, New York, 1930).
- Stevenson, George, and Smith, Geddes, *Child Guidance Clinics* (The Commonwealth Fund, New York, 1934).
- Thom, Douglas, *Everyday Problems of the Everyday Child* (D. Appleton and Company, New York, 1930).
- White, William, *The Mental Hygiene of Childhood* (Little, Brown and Company, Boston, 1929).
- Wickes, Frances, *The Inner World of Childhood* (D. Appleton and Company, New York, 1927).
- Williams, Frankwood, *Adolescence: Studies in Mental Hygiene* (Farrar and Rinehart, New York, 1930).

## PSYCHIATRY

- Appel, Kenneth E., "Drawings by Children as Aids to Personality Studies," *American Journal of Orthopsychiatry*, 1, 1931, pp. 129-151.
- Bond, Earl and Appel, Kenneth, *The Treatment of Behavior Disorders Following Encephalitis* (The Commonwealth Fund, New York, 1931).
- Brown, Sanger and Potter, Howard, *The Psychiatric Study of Problem Children* (New York State Department of Mental Hygiene, Albany, 1930).
- Economo, Constantin von, *Encephalitis Lethargica* (Oxford University Press, London, 1931).
- Freud, Sigmund, *Introductory Lectures on Psychoanalysis* (George Allen and Unwin Ltd., London, 1933).
- Hendricks, Ives, *Psychoanalysis. Facts and Theories of Psychoanalysis* (Alfred A. Knopf, New York, 1934).
- Holt, Emmett, Jr., and McIntosh, Rustin, *Diseases of Infancy and Childhood* (D. Appleton-Century Company, New York, 1933).
- Kanner, Leo, *Child Psychiatry* (Charles C. Thomas, New York, 1935).
- Moll, Albert, *The Sexual Life of the Child* (The Macmillan Company, New York, 1929).
- Sachs and Hausman, *Nervous and Mental Disorders from Birth through Adolescence* (Paul B. Hoeber, Inc., New York, 1926).



- Schroeder, Paul L., "Behavior Difficulties in Children Associated with the Results of Birth Trauma," *Journal of the American Medical Association*, 92, 1929, pp. 100-104.
- Tredgold, A. F., *Mental Deficiency* (William Wood and Co., New York, 1929).
- White, William, *Outlines of Psychiatry* (Journal of Nervous and Mental Disease Publishing Company, Washington, 1929).

## PSYCHOLOGY

- Betts, Emmett Albert, *The Prevention and Correction of Reading Difficulties* (Row, Peterson and Company, Evanston, 1936).
- Bisch, Louis E., *Clinical Psychology* (Williams and Wilkins Company, Baltimore, 1925).
- Davies, Stanley P., *Social Control of the Mentally Deficient* (Thomas Y. Crowell Company, New York, 1930).
- Elmendorf, Laura G., Jameson, Augusta T., and Perce, Frances C., *Games and Devices for Remedial Reading* (Published by the authors, 907 South Lincoln Street, Chicago, 1937).
- Gates, Arthur I., *The Improvement of Reading*, Revised Edition (The Macmillan Company, New York, 1935).
- Goddard, Henry H., *Feeble-Mindedness, Its Causes and Consequences* (The Macmillan Company, New York, 1926).
- Goodenough, Florence, *Measurement of Intelligence by Drawings* (World Book Company, Yonkers-on-Hudson, 1926).
- Jenkins, R. L., "The Management of the Retarded Child," *American Journal of Diseases of Children*, 52, 1936, pp. 599-607.
- Jersild, Arthur, *Child Psychology* (Prentice-Hall, Inc., New York, 1935).
- Monroe, Marion, *Children Who Cannot Read* (The University of Chicago Press, Chicago, 1932).
- Penrose, Lionel S., *Mental Defect* (Farrar and Rinehart, New York, 1934).
- Pintner, R. A., and Paterson, D. G., *A Scale of Performance Tests* (D. Appleton and Company, New York, 1917).

- Shaffer, Laurence Frederick, *The Psychology of Adjustment* (Houghton Mifflin Company, New York, 1936).  
 Terman, Lewis M., *Genetic Studies of Genius* (Stanford University Press, Stanford, 1925).  
 Terman, Lewis M., and Merrell, Maud A., *Measuring Intelligence* (Houghton Mifflin Company, New York, 1937).

## SOCIAL

- Addams, Jane, *The Spirit of Youth and the City Streets* (The Macmillan Company, New York, 1930).  
 Cannon, Mary and Klein, Philip, *Social Case Work* (Columbia University Press, New York, 1933).  
 Carpenter, Niles, *The Sociology of City Life* (Longmans Green & Company, New York, 1931).  
 Glueck and Glueck, *One Thousand Juvenile Delinquents* (Harvard University Press, Cambridge, 1929).  
 Hartshorne and May, *Studies in Deceit* (The Macmillan Company, New York, 1928).  
 Karpf, Maurice J., *The Scientific Basis of Social Work* (Columbia University Press, New York, 1931).  
 Landesco, John, "Crime and the Failure of Institutions in Chicago Immigrant Areas," *Journal of Criminal Law and Criminology*, 23, 1932, pp. 238-248.  
 Lee, Porter and Kenworthy, Marion, *Mental Hygiene and Social Work* (The Commonwealth Fund, New York, 1929).  
 Lumpkin, Katherine, *The Family* (The University of North Carolina Press, Chapel Hill, 1935).  
 Marcus, Grace, *Some Aspects of Relief in Family Case Work* (Charity Organization Society, New York, 1929).  
 Milford Conference, *Social Case Work, Generic and Specific* (American Association of Social Workers, New York, 1929).  
 Pound, Roscoe, *Criminal Justice in America* (Henry Holt and Company, New York, 1930).  
 Queen, Bodenhafer, and Harper, *Social Organization and Disorganization* (Thomas Y. Crowell Company, New York, 1935).  
 Reckless, Walter and Smith, Mapheus, *Juvenile Delinquency* (McGraw-Hill Book Company, Inc., New York, 1932).

- Reynolds, Bertha, and MacGregor, Madeline, *Collected Papers on Relationships in Short Contact Interviewing* (National Association for Traveler's Aid and Transient Service, New York, 1934).
- Richmond, Mary, *Social Diagnosis* (Russell Sage Foundation, New York, 1927).
- , *What Is Social Case Work?* (Russell Sage Foundation, New York, 1922).
- Robinson, Virginia P., *A Changing Psychology in Social Case Work* (The University of North Carolina Press, Chapel Hill, 1934).
- Schweinitz, Karl de, *The Art of Helping People Out of Trouble* (Houghton Mifflin Company, New York, 1924).
- Shaw, Clifford R., *The Jack-Roller* (The University of Chicago Press, Chicago, 1930).
- , *The Natural History of a Delinquent Career* (The University of Chicago Press, Chicago, 1931).
- Shaw, Clifford R. and McKay, Henry D., *Social Factors in Juvenile Delinquency*, Vol. II of Report on Causes of Crime (National Commission on Law Observance and Enforcement, Washington, 1931).
- Thomas, William and Thomas, Dorothy, *The Child in America* (Alfred A. Knopf, New York, 1928).
- Thrasher, Frederick M., *The Gang* (The University of Chicago Press, Chicago, 1929).
- Williams, Frankwood, *Russia, Youth, and the Present-day World* (Farrar and Rinehart, New York, 1934).
- Young, Pauline, *The Pilgrims of Russian-Town* (The University of Chicago Press, Chicago, 1932).

## RECREATION

- Coyle, Grace S., *Studies in Group Behavior* (Harper & Brothers, New York, 1937).
- Lehman and Witty, *The Psychology of Play Activities* (A. S. Barnes & Company, New York, 1927).
- Lowenfeld, Margaret, *Play in Childhood* (Victor Gollancz, Ltd., London, 1935).
- Schlotter and Svendsen, *An Experiment in Recreation with the Mentally Retarded* (Behavior Research Fund, Chicago, 1933).

- Van Alstyne, Dorothy, *Play Behavior and Choice of Play Materials of Preschool Children* (The University of Chicago Press, Chicago, 1932).

## THERAPY

- Aichorn, August, *Wayward Youth* (The Viking Press, New York, 1935).
- Alexander and Healy, *Roots of Crime* (Alfred A. Knopf, New York, 1935).
- Blatz, William and Bott, Helen, *Parents and the Preschool Child* (William Morrow and Co., New York, 1929).
- Burling, Temple, "The Value of Explicit Acknowledgment of the Transference," *American Journal of Orthopsychiatry*, 4, 1934, pp. 518-523.
- Fischel, Margaret, *The Spastic Child* (C. V. Mosby Company, St. Louis, 1934).
- Freud, Anna, *Technic of Child Analysis* (Nervous and Mental Disease Publishing Company, Washington, 1928).
- Healy, William, et al., *Reconstructing Behavior in Youth* (Alfred A. Knopf, New York, 1929).
- Jenkins, R. L., "The Management of the Retarded Child," *American Journal of Diseases of Children*, 52, pp. 599-607.
- Taft, Jesse, *The Dynamics of Therapy in a Controlled Relationship* (The Macmillan Company, New York, 1933).

## INDEX





## Index

### A

- Achievement tests
  - case study illustrating value of, 260-277
- Adjustment and environment, 20, 21
- Adjustment, definition of, 20
- Adjustment of handicapped children, 21
- Adjustment of the child, 20, 21
- Adolescence, case studies, 169-177; 302-310
- Adolescents, 110, 124, 125
- Agency co-operation, 41
- Antisocial behavior, 73
- Argyll-Robertson pupil, 60, 75
- Athetosis, 68
- Attention getting mechanisms, 179, 180, 183, 184
- Attitude of the child to the psychiatric examination, 136
- Attitudes, inner, 144
- Attitudes, parental, 26

### B

- Behavior of rejected children, 183, 184
- Behavior Research Fund, 326
- Behavior Research Fund Publications, 326
- Birth injury, cerebral, 66
  - behavior as affected by, 68, 69
  - convulsions in, 68
  - diagnostic difficulties in mild cases of, 69
  - factors determining educability of cases of, 69

- Birth injury, cerebral—(*continued*)
  - mental deficiency in, 68
  - muscular inco-ordination in, 68
  - orthopedic measures in, 69
  - spastic paralysis in, 67
  - symptoms, 66
  - training in cases of, 69, 70
  - treatment of, 69
- Birth palsy, 64-65

### C

- Camp Fire girls, 123-124
- Case history, 40 ff
- Case load of Institute, 327
- Cerebral spastic paralysis, 64
- Change of personality, 61
- Chicago Area Project, 327
- Childhood, characteristics of, 3
- Childhood, nature and needs, 3
- Child placement, discussion of, 227-229
- Choreiform movements, 65, 68
- Clinic at the Institute for Juvenile Research
  - departments of, 33
  - method of referring cases to, 31
  - organization of, 31-39
  - types of service at, 36-38
- Commitment of
  - delinquent, 315
  - encephalitic, 317
  - feeble-minded, 297, 298, 300
  - insane, 312
- Confession, influence of, 144
- Constitutional inadequacy, 291-315
- Control, effective, 7, 8
- Control of children, 5, 6

- Convulsions, 68, 70, 79
  - clonic, 70
  - tonic, 70
- Credit for field training, 331
- Cruelty, 73
- Cruelty to other children
  - case study of, 229-233

## D

- Delinquency
  - as an integral part of the cultural pattern, 290
  - case study of, 283-290
  - discussion of, 284-290
  - influence of slum condition on, 283
  - methods of treatment, their ineffectiveness, 288-290
  - relation to truancy, 283
  - studies of the ecology of, 277
- Delinquents, 116, 122
- Demanding attitudes, 211, 212, 215, 216, 217, 218, 219, 220
- Demonstration clinics, 331
- Dependency, 3
- Dependency—need of, 315
- Discipline, 8
- Discipline by the social group, 8
- Distractibility, 61, 68
- Dream interpretation, 141
- Dream symbols, 141
- Dreams
  - as an expression of motives, 141
  - significance of, 215

## E

- Emotions, 129
- Encephalitis, epidemic, 57
- Encephalitis, lethargic, 57 ff.
  - Argyll-Robertson pupil, 60
  - behavior in, violent, bizarre, impulsive, 59, 61, 62
  - change of personality in, 61
  - definition, 57

- Encephalitis—(*continued*)
  - differentiated from Parkinson's disease, 59, 60
  - disturbance of volition in, 59
  - incidence in I.J.R. cases, 57
  - institutionalization in, 63
  - intellectual functions in, 59
  - management in community of cases with, 64, 260
  - medical history in, 57, 58
  - muscular and speech disorders in, 60
  - narcolepsy, 58
  - Parkinsonism, 59, 62, 63
  - pathology, 57, 64
  - polymorphous character of, 58
  - prognosis of, 58, 61, 63
  - pupillary responses in, 60
  - reflexes in, 60
  - reversal of sleep cycle, 58
  - self-mutilation in, 62, 63
  - sex misconduct in, 61
  - treatment of, 63, 64
- Encephalopathies, group of, 64 ff.
  - antenatal, 64 ff.
  - description of, general, 64, 65
  - infantile, 64 ff.
  - natal, 64 ff.
  - residuals of, 66, 67
- Endocrine glands, 78
  - adrenal glands, 79
  - Cretinism, 78
  - gonads, 78
  - hypophysis, 78, 79
  - pancreas, 79
    - hypoglycemia, 79
  - parathyroid glands, 78
  - relation to behavior, 78
- Enuresis, 189
  - case study of, 260-277
- Environment and adjustment, 20, 21
- Environment as a problem, 12
- Environment, change of, 21
- Environment, unfavorable, 22
- Epilepsy, 70

Epilepsy—(*continued*)

- aura in, 70, 71
  - behavior manifestations in, 72
  - convulsions in, 70, 71
  - description, 70
  - emotional and intellectual deterioration in, 73
  - "epileptic equivalents," 71
  - epileptic furor, 72
  - grand mal seizures, 70, 71
  - petit mal seizures, 71
  - post-convulsive behavior in, 71, 72
  - treatment in, 73
- Epilepsy, Jacksonian type, 71 ff.
- Epileptic constitution, 72, 73

## F

- Family inter-relationships
  - case study illustrating influence of, 237-248
- Fantasies, sexual, 210, 215
- Feeble-mindedness, 295
  - commitment, 297, 298, 300
  - Rome Colony, New York, 301
- Feeding problems
  - case study illustrating, 248-260
- Field training center, 330
  - in psychiatric social work, 330
  - in psychiatry, 330
  - in psychology, 330
  - in sociology, 330
- Free association, 141, 142
- Functions of Institute for Juvenile Research, 323

## G

- Gangs, 116, 121
- Group membership, 107, 113, 117, 121, 122, 123, 124, 125, 126, 127, 128
- Growth
  - interference with, 163-177

## H

- Hallucinations, 72, 75
- Handicaps
  - effect of, 21
- Healy, William, 322
- Hearing defect, 76
- History
  - use of social, 40 ff.

## I

- Identification, 143
- Impulsiveness, 61
- Independence
  - need of, 3, 5
- Infantile cerebral paralysis, 64
- Infantile diplegia, 64, 67
- Infantile hemiplegia, 64, 67
- Infantile paraplegia, 64, 67
- Information about the patient, use of, 142
- Instincts, 6, 7
- Institute for Juvenile Research
  - Psychopathic Institute, 321
- Intelligence quotient
  - classification of, 87
  - constancy, 85
  - definition, 85
  - factors influencing, 85, 88
  - relation to mental maturity, 86
- Intelligence tests
  - case study illustrating value of, 260-277
- Interpretations, 131
- Interview, intake, 40-45, 48-49

## J

- Jealousy of younger siblings, 193, 194
- Juvenile Court, 321
  - dependency petition, 312
  - Detention Home, 305, 313
- Juvenile Psychopathic Institute, 321

## L

Lecture Courses, 332  
 Little's disease, 64  
 Loyalties of children, 15

## M

Malnutrition, 312  
 Masturbation  
   case study of, 223-226  
 Maternal rejection, 182, 183, 202,  
   203, 204  
 Medical disorders, 79, 80  
 Mental Age,  
   concept of, 84  
 Mental defective  
   the case of, 11  
 Mental deficiency, 68, 73, 77  
 Mental retardation  
   and delinquency, 296-298, 307-  
   310  
   case studies, 163-167, 291-302  
   prevocational school for retarded  
   child, 297  
   private schools for retarded child,  
   300  
   special rooms for retarded child,  
   299-300  
 Misbehavior in school, 179, 180  
 Mongolism, 76  
   description of, 77  
   diagnosis of, 76  
   differential diagnosis, 78  
   etiology of, 77, 78  
   mental deficiency in, 77  
   mortality in, 78  
 Monroe diagnostic reading exam-  
   ination, 262, 273  
 Motives, 129, 130, 143  
 Motives  
   concealment of, 140  
 Movies, 112, 113  
 Muscular incoördination, 60, 68

## N

Negativism, 12, 163-167, 189  
 Neighborhood projects, 128  
 Nervous System and Special Senses,  
   57 ff.  
 Normal Probability Curve, 86, 87

## O

Old World standards, 303, 306  
 Only child, case study of, 248-260  
 Outline, history, 40 ff.  
   content of, 46  
   limitations of, 45, 51  
   use of, 40-45, 47-51  
 Outline of psychotherapy and other  
   aids in adjustment, 155-  
   159  
   direct aid through psychiatric  
   interviews, 155-158  
   devices depending upon ap-  
   proval, 156  
   devices depending upon au-  
   thority at a superficial  
   level, 156  
   devices depending upon au-  
   thority at a deeper level,  
   156  
   devices depending upon pa-  
   tient's intelligence, 156  
   procedure combining intellec-  
   tual and emotional ap-  
   proaches, 157  
   process concerned with emo-  
   tions at a deeper level, 157  
   process of releasing patient  
   from emotional conflict,  
   157  
   indirect therapy, 158  
   aids involving interpersonal  
   relationships, 159  
   aids not greatly involving in-  
   trapersonal relationships,  
   158  
 Over-anxiety of parents, 12



- Overdependence, 194
- Over-excitability, 61, 68
- Over-protected child
  - case study of, 248-260
- Over-solicitude on part of parent,
  - 189, 193, 194

## P

- Parental attitudes
  - case study illustrating influence of, 237-248, 248-260
  - discussion of influence of, 256-260
- Parental conflict
  - case studies illustrating influence of, 237-260
- Parental favoritism
  - case study illustrating influence of, 237-277
- Parental over-anxiety
  - case study illustrating influence of, 248-260
- Parental sex maladjustment, 246
- Parents, uncoöperative, 27
- Passivity, 168
- Pediatrician, duties of, 35
- Period of direction, 329
- Personality, its growth, 4
- Personality problems
  - deep seated, 10
  - superficial, 10
- Personal equation in psychiatry,
  - 131
- Philosophy of child guidance, 16
- Physical diseases, relation of to behavior problems, 54
- Physical examination, 54 ff.
  - attitude of child toward, 55
  - effect on child, 55
  - importance and relation to total examination, 54
  - painful procedures, proper handling of, 56
- Physicians, training in psychiatry,
  - 331

- Placement
  - boarding home, 313
  - camp, 303, 315
- Play
  - individual differences, 109
  - interests, 112, 118, 126
  - make-believe, 112
  - of gifted children, 117, 118
  - of mentally retarded, 116, 117
  - of physically handicapped, 115, 116
  - parents role in, 107, 108
  - theories, 108
- Play therapy, 146
- Preparation for birth of sibling,
  - 194
- Problems, environmental, 12
  - of normal behavior, 13
  - reported to child guidance clinics, 17
- Projection, 143
- Psychiatric examination, 134, 135
  - interview, 132-134
  - techniques, 134, 136, 137, 138, 146
- Psychiatrist, contribution of, 129-132
  - role of, 131
- Psychiatrist's attitude to child, 139
  - training, 35, 143-145
- Psychiatry, amateur, 144
  - clinical training in, 331
- Psychiatry, dangers of, 144
- Psychoanalysis, 310
  - different from psychiatry, 145
- Psychologist
  - training and duties of, 34
  - work of, 81, 105
- Psychopathic hospital, 312
- Psychopathic personality, 312
- Psychotherapy, 207, 208, 209
- Publications, Behavior Research Fund, 326
- Punishment, 311
- Punishment as discipline, 8

## Q

- Quarrelsomeness in children
  - case studies of, 237-277
- Questions, use of in first interview, 45-46

## R

- Reading difficulty, 180
  - analysis of, 262-265
  - case study illustrating influence of, 260-277
  - discussion of, 273-277
  - ophthalmological examinations in, 263-264
  - relation to other behavior difficulties, 273-277
  - relation to school retardation, 262
  - treatment of, 266-273
- Recreation
  - facilities, 109, 115, 116, 117, 120, 121, 122, 123, 124, 125, 126, 127, 128
  - interview, 110, 111, 112, 113, 114
  - outlines, 110
  - service, 109, 121
  - study of, 109, 110, 111, 112, 113, 114, 115
  - workers, 109, 114, 118, 127, 128
- Recreation service, 34, 35
- Referral sources, 323
- Regressive behavior, 194
- Repressive measures, 168, 175
- Resources of community available for treatment program, 151-155
  - case working agency, 153
  - child guidance clinic, 151
  - foster home placement, 154
  - home, 152
  - institutional placement, 154, 155
  - law, 152
  - organized recreational programs, 153, 154

Resources—(*continued*)

- placement outside the home, 154-155
- school, 152-153
  - benefits from, 154
  - necessities for, 154
- Reward as discipline, 8
- Role of the interviewer, 45, 46, 47, 48

## S

- School teachers, training in psychology, 331
- Scout organizations, 116, 121, 122, 123, 124
- Seclusiveness, 10
- Seizures, epileptiform, 72
- Self-control, 5
- Settlements, 118, 124, 127
- Sex misconduct, 61
- Sex trauma, 302
- Sexual maladjustment of parents, 246
- Sibling jealousy
  - case study of, 237-248, 260-277
- Siblings, competition, 194, 195, 196
- Sleep disturbance, 58
- Sleeping sickness, 57
- Social case history, 40 ff.
- Social history, 120
- Social interview, first, 40-45, 48-49
  - participation of client in, 48
  - treatment in, 45
  - use of questions in, 45-46
- Social needs of children, 7
- Social worker, 40 ff.
- Social worker
  - duties of, 34, 38
  - training of, 33
- Soiling, 189
- Sources of referral, 323
- Spoiled child
  - case study of, 229-233, 248-260
- Standards of children, 9
- Stealing, 11, 302, 308, 312

- Strumpell's encephalitis, 64  
 Stubbornness, 14  
 Summer camps, 124, 127  
 Superior intelligence, 168, 303, 311  
 Syphilis, 73  
   Argyll-Robertson pupil in, 75  
   congenital type, 74  
   disturbances of sensation in, 74  
   epitrochlear gland enlargement in, 74  
   history in congenital infections of, 74  
   incidence in IJR cases, 73  
   incidence of neuro-syphilis in IJR cases, 73, 74  
   juvenile paresis, symptoms, 75  
   mental deterioration, 75  
   paralysis in, 74  
   pupillary irregularity in, 75  
   reflexes in, 75  
   symptoms of nervous system invasion in, 74  
   treatment of, 75

## T

- Teachableness of children, 7  
 Teacher training colleges, 331  
 Teaching program, 330  
 Temper tantrums, 11, 163, 310-317  
   case studies of, 229-233, 237-248

## Tests

- educational, 96  
   diagnostic, 98, 101  
     Buswell diagnostic arithmetic, 101  
     Compass diagnostic arithmetic, 101  
     Gates diagnostic reading, 100  
     Monroe diagnostic reading, 98, 100  
   discussion of, 96  
   general, 96, 98

## Tests

- general—(*continued*)  
   New Stanford Achievement, 97  
   group tests, 93  
     Army Alpha, 93  
   individual, 90, 93  
     Herring revision of Binet  
     Kuhlman revision of Binet  
     Stanford-Binet  
   non-language and performance  
     Cornell-Coxe  
     general discussion of  
     Gesell schedules  
     Goodenough drawing a man  
     Grace Arthur  
     Kohs block design  
     Merrill-Palmer  
     Minnesota Pre-School  
     Pintner-Patterson  
     Porteus Maze  
   of general intelligence, 90, 93  
   reliability of, 83  
   standardization of, 82, 83  
   validity of, 83  
   vocational  
     discussion of, 101  
     I. E. R. clerical, 102  
     Kwalwasser-Dykema, 102  
     Lewerenz Fundamental Abilities of visual art, 103  
     Meier-Seashore Art Judgment, 102  
     Minnesota Mechanical, 101  
     Personality schedules, 104, 105  
       Bernreuter, 105  
       Thurstone, 105  
     Seashore Musical, 102  
     Stenquest Mechanical, 101  
     value of, 103-104  
     vocational questionnaires, 104  
       Garrestson, 104  
       Strong, 104  
 Therapy, 23-25  
 Therapy and the parent, 25-26

Therapy by tutoring, 23-24  
Therapy, environmental, 21-24  
Therapy, physical, 22  
Therapy, psychiatric, 22  
Therapy, recreational, 25  
Toys, 111-113

Treatment  
  case studies illustrating difficulties  
    encountered in, 229-237  
  changing of parental attitudes,  
    186, 187  
  enuresis, 191  
  of reading difficulty, 266  
  prognosis, 16  
  soiling, 191  
Tutoring, reading, 185

## U

University graduate credit, 331  
Unmanageable child, case study of,  
  237-248  
Unwanted child, case study of,  
  260-277

## V

Visiting clinics, 325-328  
Visual defects, 76

## Y

Y. M. C. A., 121, 124, 127

(1)









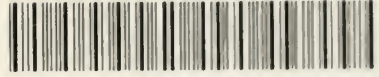








Child guidance procedures: main  
136.76129c C.2



3 1262 03153 1527

